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January 1957 ★ VOLUME 53 ★ NUMBER 1

The Ohio State MEDICAL JOURNAL

AMA Session:
What the House of Delegates Did at Seattle Meeting . . . . Page 65

1957 Annual Meeting:
New Setting, New Features for OSMA Session, May 14-16 . . Page 71

Medicare Program in Ohio:
Latest Developments on Care Of Military Dependents . . . Page 72

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Complete Index on Inside Front Cover

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Summary of Contents

Managements of Patients with Major Burns; An Outline for the Hospital Staff. John R. Brown, M. D.; P. A. Weisman, M. D., and G. G. Ediss, M. D., Dayton 37

Keeping Up With Medicine. Jonathan Forman, M. D., Columbus 40

Trichobezoar: Survival Following Complication of Perforated Ulcer. James E. Mullen, M. D., Toledo 41

Local Injection of Prednisolone TBA in the Treatment of Rheumatic Diseases. Norman O. Rothermich, M. D., and Vol K. Philips, M. D., Columbus 45

Clinical Observations with a Nystatin and Fluorohydrocortisone Ointment. Roy L. Kile, M. D., Cincinnati 47

The Status and Progress of the Receiving Hospitals in Ohio. Eugene E. Elder, M. D., Youngstown 49

Franklin County Pelvic Cancer Delay Committee Report. John H. Holzaepfel, M. D., Columbus 50

Maternal Mortality and the Role of the Local Health Department in Prevention of These Deaths. Anthony Ruppersberg, Jr., M. D., Columbus 51

Maternal Health in Ohio 55

Clinicopathological Conference 58

The Historian's Notebook: The Medical Men in George Washington's Life—Part I. Victor R. Turner, M. D., Newark 62

Rare Historical Collection (of letters and autographs) 64

Physician's Bookshelf 18
Report of AMA Session in Seattle 65
Hotel Reservation Page for 1957 OSMA Annual Meeting 70
New Setting and New Features for the 1957 Annual Meeting 71
Medicare Program in Ohio—Latest Developments on New Program 72
Central Ohio Heart Association Program 74
Washington Roundup 75
Workmen's Compensation Fee Bills and Signatures 76
No Need To File X-Ray Films, W. C. Bureau Decides, if Two Conditions Are Met 77
Course on Diabetes at OSU 78
Urges Stepped-Up Polio Immunization Program 80
New Members of OSMA 80
Mental Hygiene—A Parting Message by Dr. Porterfield 82
A Choice To Make—Message of the President of the AMA 83
Medical Education Week 86
Pre-School Health 90
Fulton County Youth Wins First OSMA Award in 4-H Club Health Contest 92

In Our Opinion:
New Patient Information Card Helps Efficiency 94
Medical Society as Leader of Community's Progress 94
Internal Revenue Ruling Appears To Split Hairs 94
Physicians Can Prevent Improper Use of Drugs 94
Medical Men Can Help Reduce Highway Deaths 94
Main Reasons for Suits of Malpractice Listed 95
Britain's 'Dream' Medicine Is More Like a Nightmare 95
Hoxsey Cancer Treatment Declared a Fraud by Another Court 95
Iowa Doctor-Hospital Dispute 97
Bureau of Workmen's Compensation, Actuarial Report 100
In Memoriam 102
Sir Edward Appleton To Be Cincinnati Centennial Speaker 103
Activities of County Societies 106
Activities of Woman's Auxiliary 110
Bunts Institute in Cleveland Announces Courses 114
Index To Advertisers 114
Classified Advertisements 115



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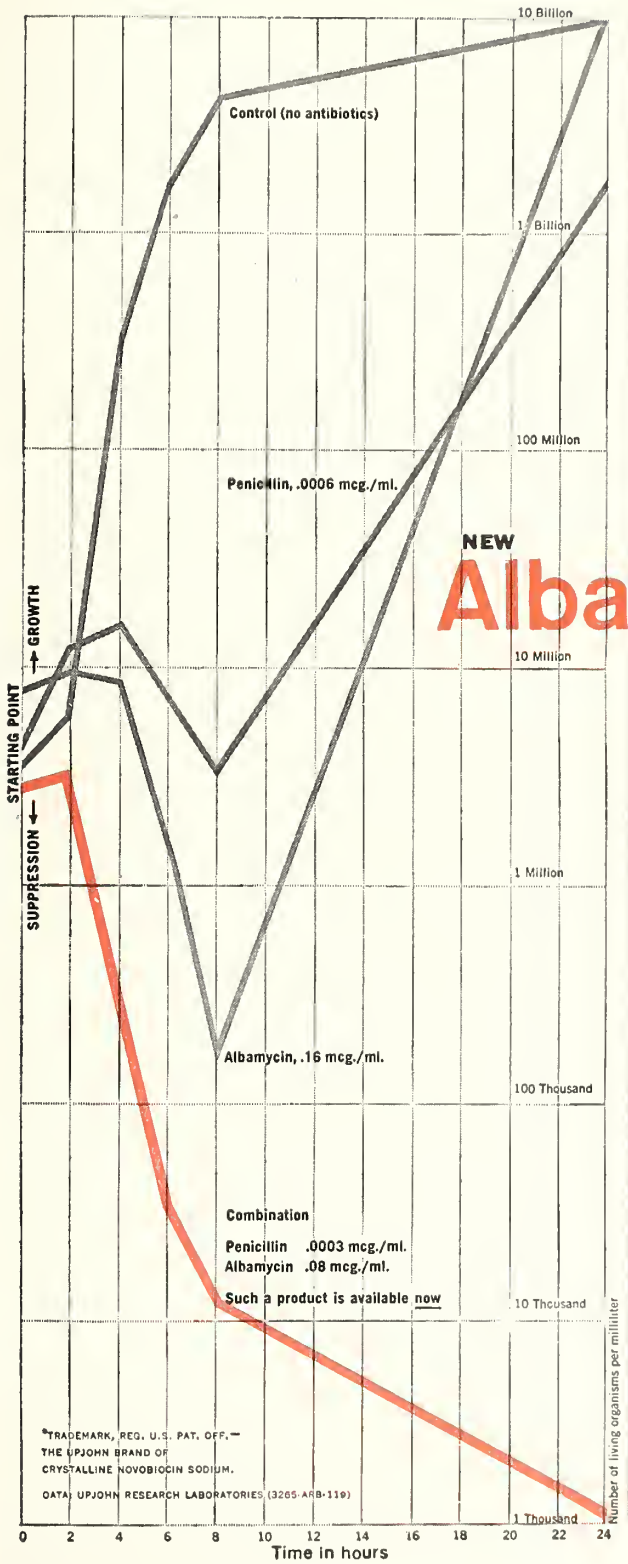
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†Abrahamson, I. A., Jr., and Abrahamson, I. A., Sr.: Am. J. Ophth. *42*:482, 1956.

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Physiotherapy in Some Surgical Conditions, by Joan E. Cash, ($5.00. *J. B. Lippincott, Philadelphia 5, Pa.).* This book tries to show how physiotherapy is of value in some of the diseases and injuries treated by surgeons. There are 343 pages of detailed information on these various conditions, making this an extremely worthwhile manual in its field.

Pomp and Pestilence; Infectious Disease, Its Origins and Conquest, by Ronald Hare, M. D., Prof. Bacteriology, University of London, England, ($5.75. *The Philosophical Library, Inc., New York 16, N. Y.).* A fascinating story of the origin and nature of parasitism. The author then traces the spread of infectious diseases throughout the whole period of recorded history. He then goes on to tell the story of several of the great epidemics. More interesting, however, to your reviewer is the chapter on Man's various concepts and beliefs about the nature of these diseases and their influence on Man's behavior and medicine. It is in fact a popular book in the best sense of the word.

The Doctor's Legacy, edited by Laurence Farmer, M. D., ($3.50. *Harper and Brothers, New York 16, N. Y.).* A selection of intimate letters from doctors to their colleagues, friends, and patients which bring to life the great moments in 200 years of modern medicine.

Practical Mycology: A Manual for Identification of Fungi, by Sigurd Funder, ($6.50. *Broggers Bokta Foklag, Oslo, Norway;* United States distributor, *Hafner Publishing Co., New York, New York).* This manual is designed for beginners and as an aid to those who without any special botanical knowledge are interested in identifying the common fungi which as bacteriologists, physicians, veterinarians they meet in their work. The steady increase in our knowledge of fungi as pathogens and allergens makes the book of great value to our profession.

Understanding the Japanese Mind, by James Clark Moloney, M. D., ($3.50. *Philosophical Library, Inc., New York 16, N. Y.).* The author examines the plausible thesis that systems of psychotherapy are culture-bound in the sense of their being involved with implicitly assumed goals which differ from society to society. Japanese psychoanalysis, for instance has undergone change upon importation. Japanese psychoanalysis aims at reinforcing pressures toward categorical and arbitrary conformity. Dr. Moloney reaches the conclusion that the hierarchi authoritarianism of historical Japanese culture is incompatible with the liberalism of Western psychoanalysis which is based upon respect for the individual and aims at his self-realization —not a resentencing to the same cultural reformatory.

Cough Syncope, by Vincent J. Derbes, M. D., and Andrew Kerr, Jr., M. D., ($4.75. *C. C. Thomas, Springfield, Ill.).* Here has been brought together the literature on this subject from the fields of otolaryngology, neurology, psychiatry, pediatrics and general medicine. Twenty-five cases coming under the personal observation of the author's life to this literary background. To these have been added 10 cases observed by colleagues. Not since 1902 has a similarly extensive experience been presented. The book also contains a discussion of certain topics pertinent to this syndrome, such as fainting, epilepsy, the laryngeal crisis of tabes dorsalis, voluntary death by breath holding and the medicolegal aspects of the syndrome itself.

Clinical Neuro-Surgery: Proceedings of Congress of Neurological Surgeons, ($6.75. *Williams and Wilkins Co., Baltimore, Md.).* Following the usual pattern the meeting does honor to one man. Five addresses were given by Kenneth G. McKenzie, M. D., professor of surgery at the University of Toronto. Two panel discussions form the rest of the book. These were on the medical-legal aspects of head injuries and the legal aspects of epilepsy.

Smoking and Cancer: A Doctor's Report, by Alton Ochsner, M. D. ($2.00. *Julian Messner, Inc., New York 18, N. Y.)* An excellent presentation of the Medical case against tobacco.

Cells and Societies by J. T. Bonner. ($4.50. *Princeton University Press, Princeton, N. J.)* How many types of organisms meet their requirements for the necessities of feeding, reproduction and social coordination from Amoeba to the howling monkeys of Barro Colorado Island forms the theme of this book. The fact that all societies of animals have these activities in common gives the author the chance to compare them on equal terms.

A Therapeutic Index, by C. M. Miller, M. D., and B. K. Ellenbogen, M. D. ($3.75. *Williams and Wilkins, Baltimore 2, Md.)* A houseman's and physician's pocket guide-book from Liverpool, and a good one too.

Battalion Medics, A Novel of the Korean War, by Van B. Philpot, Jr., ($3.00. *Exposition Press New York 10, N. Y.).* A Southern doctor who learns that there are no bigots in foxholes. The impact of close association of whites and Negroes

(Continued on Page 20)

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fighting yellow men, all on equal terms, upon his Mississippi culture is the theme. Upon returning home he rebels against his native culture and pays the price for it. If one wishes to view the racial problem through the eyes of a native of the deep south and then through the eyes of one whose eyes have been opened in Korea, one will enjoy this novel.

Handbook for Diabetic Children, by Alfred E. Fischer, M. D., and Dorothea L. Horstmann, ($1.75. *Intercontinental Medical Book Corp., New York 16, N. Y.).* This handbook has been prepared to help young people learn how to manage their diabetes. It has been written at the level of children so that it can be understood. In addition to explaining the nature of the disorder and the proper use of insulin, it attempts to teach sound principles of nutrition.

A Developmental Study of the Behavior Problems of Normal Children Between 21 Months and 14 Years, by Jean W. McFarlane, Lucille Allen and Marjorie P. Honzits, ($2.25. *University of California Press, Berkeley and Los Angeles, Calif.),* presents a statistical analysis of some 30 behavior patterns for more than 100 children collected at yearly intervals for 14 years. This study shows clearly that we must have more longitudinal studies such as this pioneering attempt before we are going to understand correctly the relationship of early experiences and behavior to later behavior and personality, and the processes by which stable personality patterns are established.

Body Fluids in Clinical Medicine, by Alexander Leaf, M. D., and L. H. Newburgh, M. D., ($2.50. *Charles C. Thomas, Springfield, Ill.).* These lectures fully describe the characteristics of extracellular fluid and show how their knowledge can increase our understanding of disease and can therefore be useful in clinical therapeutics. In this edition, too, it has been possible, due to recent advances gained from research, to include some far reaching data on disturbance of fluids within the cell of great clinical significance.

Medical Students and Medical Science, by David Sinclair, M. D., ($5.00. *Oxford University Press, New York, N. Y.).* This is a discussion of some of the problems of education in Britain and the United States by the Oxford anatomist. The book deals with such matters as the selection of medical students, the way in which they are taught and assessed, the relation of medical science to the medical curriculum and the ideas underlying the various experiments in medical education in progress at present.

Your Feet and Their Care, by William A. Rossi, ($3.00. *Emerson Books, Inc., New York, N. Y.).* There certainly is need for a book such as this. Most physicians will agree with your reviewer that the most distressing feature of a physical examination on people past 50 is the deformed misshapen feet of the examined. This book may convince the younger reader of the disabling effects of improperly fitting shoes and of bad feet on other parts of the body. Certainly also is the reward that comes to those who will take care of their feet in efficiency and freedom from distress. No relief from pain or physical torture is so gratifying as relief from foot trouble.

Classics of Biology, by August Pi Suner, translated by Charles M. Stern, ($7.50. *Philosophical Library, New York 16, N. Y.).* Teachers of biology, philosophy and the history of science or any of its branches as well as the general reader will welcome this book by the outstanding Spanish physiologist. The author illuminates the high points of the progress in the study of biology by providing fascinating glimpses of the philosophical theories which have been propounded in different ages up to our time. Famous controversies are discussed and extensive textual extracts from outstanding works of more than 60 writers introduce the reader to thinkers of the finest caliber whose fame is more widely known outside the English speaking world.

Fluid Therapy, by James D. Hardy, M. D. ($5.50. *Lea & Febiger, Philadelphia 6, Pa.).* Many of the recent advances in both medical and surgical management of patient have become possible because of a better understanding of physiologic needs and in few fields have advances been more rapid than in that of fluid metabolism. Here we have a concise discussion of total fluid therapy.

1955-1956: Year Book of Pediatrics, edited by Sydney S. Gellis, M. D., ($6.00. *Year Book Publishers, Inc., Chicago 11, Ill.).* As in previous issues, physicians with special interests have been asked to comment on various papers or to clarify some controversial points raised in current papers. This procedure adds greatly to the value of the text.

The Family of Man: A Photographic Exhibition Created by Edward Steichen with prologue by Carl Sandberg, ($10.00. *Maco Magazine Corp., Lexington Ave., New York, N. Y.).* Five hundred and three pictures from sixty-eight countries tell the story of mankind for the Museum of Modern Art.

The Presbyterian Hospital and the Columbia-Presbyterian Medical Center 1868-1943, by Albert Richard Lamb, M. D., ($8.75. *Columbia University Press, New York 27, N. Y.).* The seventy-five years of development and service that brought the Presbyterian Hospital and the modern Medical Center to a position of eminence in the world of medicine and of man, are here recorded by one who was closely associated with the institutions for nearly 50 years.

Therapy of Fungus Diseases: An International Symposium, edited by Thomas H. Sternberg,

M. D., and Victor D. Newcomer, M. D., ($7.50. *Little Brown and Company, Boston 6, Mass.*). At the symposium on which this book is based some 200 leading authorities participated. The 56 papers provide an up-to-date review of a field in medicine that is becoming of increasing importance. In addition to an evaluation of all of the new remedies there is a most informative discussion of the biologic aspects of fungus infections.

Scientific Writing, by M. R. Emberger, and M. R. Hall, ($4.50. *Harcourt, Brace and Co., Inc., New York 17, N. Y.*). There has been a great increase in the interest of medical men in writing as shown by the rapid growth of The American Medical Writers' Association and its annual convention. This text from the University of Louisville will be helpful to all who are interested in improving their own efforts. It will help to form the background for the Workshop in Medical Writing at the Annual Meeting of the Ohio State Medical Association.

Ministry and Medicine in Human Relations, edited by Iago Galdston, M. D., ($3.50. *The New York Academy of Medicine, by International Universities Press, Inc., New York 11, N. Y.*). This work is a conjoint effort at the historical reconcilation of the functions of the two professions. The emphasis is in the operational commitments of the minister and the physician and only remotely and inferentially with institutional religion and with formal science.

Impartial Medical Testimony, A Report by a Special Committee of the Association of the Bar of the City of New York on the Expert Medical Testimony Project, ($3.95. *Macmillan Company, New York 11, N. Y.*). This project instituted panels of neutral outstanding physicians on various specialized branches of medicine. These experts are available at the call of the court to make medical examinations of plaintiffs in personal injury cases, report their findings, and if necessary, testify in these cases in which medical aspects are controversial and substantial. This is an interesting report of the apparent success of the project. A book of interest to lawyers and physicans who testify frequently as experts.

Retrolental Fibroplasia—Role of Oxygen: The Sixteenth M & R Pediatric Research Conference. (Apply, *Ross Laboratories, Columbus, Ohio*). The symposium presents two aspects of the problem of retrolental fibroplasia: clinical and experimental studies concerning the role of oxygen in the etiology of this clinical entity; and elaboration of the possible mechanisms whereby oxygen exerts a toxic effect on the eye. Discussions cover response to high oxygen tensions by specific systems of the eye as well as general biochemical and histopathologic considerations.

Health, Culture, and Community; Case Studies of Public Programs, edited by Benjamin D. Paul, ($5.00. *Russell Sage Foundation, New York 22, New York*). This is the work of behavioral or social scientists from the Harvard School in cooperation with the Russell Sage Foundation. It is an attempt to demonstrate that it is in the "public" part of public health that we are weak: the "health" aspects somehow seem simpler. The public health worker and the behavior specialist are concerned in this book with getting together to resolve this problem of motivation and understanding.

Applied Medical Bibliography, by William D. Postell, ($4.50. *C. C. Thomas, Publisher, Springfield, Ill.*). The present-day concept is that the library's function is the best single criterion on which to judge a medical school. This places a greatly increased responsibility on the librarian. This book, then, is designed as a text for the student on how to use the library.

The American Drug Index, by C. O. Wilson, Ph. D., and T. E. Jones, M. S., ($5.00. *J. B. Lippincott Company, Philadelphia 5, Pa.*). This index has been prepared for the identification and correlation of the many pharmaceuticals available to the medical profession. The need for this work has become acute as the number of drugs and drug products has multiplied and each house offers them under a different trade name.

Regnery's Modern Health: Tuberculosis, by Cedric Shaw, ($2.25.) **Varicose Veins**, by R. Rowden Foote, M. D., ($2.25.) **Heart Disease**, by Geoffrey Bourne, M. D., ($2.25) **Skin Diseases**, by Reginald T. Brain, M. D., ($2.25.) *(Henry Regnery Company, 20 W. Jackson Blvd., Chicago 4, Ill.)*. This series of "disease" books gives precise, authoritative information on their respective subjects. They are designed to take the patient into the physician's confidence so that they can work together for the good of the patient.

Animal Sanitation and Disease Control, by Ralph Dykstra, ($5.00. *Interstate Publishers, Danville, Illinois)*, is designed for young minds in the hope that they may learn the importance of the role that the veterinarian has played in conserving America's immense livestock industry, as well as the favorable influence this has had upon human health and welfare.

Anesthesia in Ophthalmology, by Walter S. Atkinson, M. D., ($3.25. *C. C. Thomas Publisher, Springfield, Ill.*). The purpose of this monograph is to assemble and make easily available the generally accepted methods of producing anesthesia preparatory to operating upon the eye.

Krebiozen—The Great Cancer, by George D. Stoddard, ($3.50. *The Beacon Press, Boston, Massachusetts)*. Dr. Stoddard, who lost his position as president of the University of Illinois as a result of the controversy over this preparation, has condensed for us the 7,000 pages of the

manuscript of the hearings with its million words in 280 pages. The publication of this book was banned in Boston for three months and so attracted wide attention. A case of censorship that is alarming in its implication.

Community Programs for Mental Health: Theory—Practice—Evaluation, edited by Ruth Kotinsky and Helen L. Witmer, ($5.00. A Commonwealth Fund Book from *Harvard University Press, Cambridge, Mass.).* A symposium dealing with the current efforts to maintain mental health at optimum level on a community-wide basis.

Hypertension, 2nd Edition, by Irvine H. Page, M. D., ($3.00. *C. C. Thomas, Publisher, Springfield, Ill.).* This small book tells the patient in simple language (1) what high blood pressure is, (2) what can be done to relieve it, (3) how the hypertensive can live comfortably, as well as a full discussion of the value of the newer drugs.

Every Other Bed, by Mike Gorman, ($4.00. *The World Publishing Company, Cleveland 2, Ohio).* The Executive Director of the National Mental Health Committee tells the story of his cause. The book is essentially a documentary plea for a vast increase in expenditures for psychiatric research coupled with a lengthy analysis of the pressing problem waiting for such investigations.

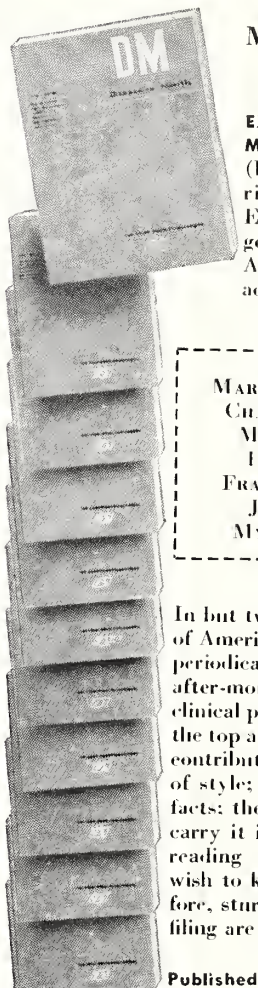
Clinical Toxicology, by Clinton H. Thienes, M. D., and Johmas J. Haley, Ph. D., ($6.50. 3rd edition, *Lea & Febiger, Philadelphia 6, Pa.).* This is a text designed as a guide for the general practitioner. It is strictly a text on Poisoning and not Pharmacology.

Doctor, Patient and the Law, 3rd edition, by Louis J. Regan, M. D., LL. B., ($12.50. *C. V. Mosby Co., St. Louis 3, Mo.).* This book deals with special medical skills in medicolegal investigations, as well as the unique duties, privileges and obligations of the physician before the law.

Alcoholism: Its scope, cause, and treatment, by Ruth Fox, M. D., and Peter Lyon, ($3.00. *Random House, Inc., New York 22, N. Y.)* This is a complete discussion of the subject by a well trained psychiatrist. It therefore will serve as a useful guide for any or all who deal with any phase of the problem or any of its victims.

Gynecologic Cancer, by James A. Corscaden, M. D., ($10.00. Second Edition. *The Williams & Wilkins Co., Baltimore, Md.).* The purpose of this book according to the author is to narrow the gap between the number of cures now generally accomplished and those which are being obtained in patients who are properly diagnosed and treated. This is especially valuable to all who are concerned with the early detection of gynecologic cancer.

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JONATHAN FORMAN, M. D., *Editor*

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Managements of Patients with Major Burns: An Outline for the Hospital Staff

JOHN R. BROWN, M.D.; P. A. WEISMAN, M.D., and G. G. EDISS, M.D.

DURING the past 15 years three major changes have occurred in the treatment of burn patients. The change from violent scrubbing and the application of tannic acid to more gentle debridement and the application of pressure dressings, the treatment of fluid and electrolyte imbalance, and the return to the open method of treatment of the burn surface have contributed greatly to obtaining a successful result in severely burned individuals.

Because of these rapid changes there is some doubt in the minds of many individuals regarding the proper use of each of these principles. At the suggestion of the Surgical Section of the Good Samaritan Hospital, Dayton, Ohio, the following outline was developed for a more standardized management of major burns. This has been mimeographed and copies distributed to the attending staff, the house staff, and the nursing staff so that each group will be ready to work with the greatest efficiency immediately on the admission of one or more patients with major burns.

Frequent careful observation of the patient and the individualization of therapy must be used with every portion of this outline. Care of the burn wound has been differentiated in the outline from general therapy to make for continuity of thought. Usually the care of the burn wound can begin after intravenous fluids have been started.

I. **Definition**: The following injuries are considered to be "major burns" and to require hospitalization:

Submitted May 17, 1956.

The Authors

- Dr. Brown, Dayton, is associate attending surgeon at Good Samaritan Hospital and at Miami Valley Hospital; junior attending surgeon, St. Elizabeth Hospital.
- Dr. Weisman, Dayton, is on active attending staff, plastic surgery, Good Samaritan Hospital, and associate attending staff in surgery, Miami Valley Hospital.
- Dr. Ediss, Dayton, is associate attending surgeon, Good Samaritan Hospital; junior attending surgeon, St. Elizabeth Hospital.

A. Second degree burns over 15 per cent of body surface;

B. Third degree burns over 5 per cent of body surface;

C. Burns combined with fractures, lacerations, and other injuries, or complicated by diabetes, psychosis, senility, or other complicating conditions;

D. Burns of eyes, respiratory tract, or genitalia.

II. **Classification**: Burn injuries should be classified in each of the following categories:

A. ETIOLOGY: Thermal, chemical (acid, alkali), electrical, radiation, and combinations;

B. DEPTH: "It is deeper than you think." First degree burns are characterized by erythema

without blister formation. Second degree burns are characterized by the formation of blisters which are usually unbroken. Third degree burns are characterized by complete destruction of the epithelium and perhaps deeper tissues as well. (This is usually indicated by broken blisters.) The tissue may be very pale, charred black, or occasionally transparent. "Any extensive flame burn or scald may be assumed to be largely third degree with little likelihood of error."[1]

C. Extent: The correct estimation of the extent of second and third degree burns is vital and should be charted immediately. The figures obtained will play a large role in estimating the amounts of fluid and electrolytes necessary for adequate treatment. The rule of nine is most practical for rapid measurement. The head and neck represent 9 per cent of skin surface, each upper extremity 9 per cent, each lower extremity 18 per cent, the front of the trunk 18 per cent and back of the trunk 18 per cent. The remainder is usually attributed to the genital areas. In younger children a somewhat larger percentage should be attributed to the head and upper extremities and a lesser percentage to the lower extremities.

D. Anatomic Distribution: Burns of the respiratory tract, eye, hands, and genitalia require particularly close attention. Respiratory distress should be watched for very carefully in the first 48 hours. Rapid respirations, cyanosis, and hoarseness indicate trouble. If in doubt do an immediate tracheotomy and administer oxygen.

III. General Therapy: Recommended treatment must be modified by frequent review of the patient's status, especially in the first 48 hours. Careful clinical observation, good judgement and flexibility are essential.

A. Emergency Treatment

1. General history and physical examination. Weigh patient.

2. Complete blood count, hematocrit, urinalysis, blood type, and cross match.

3. Sedation with demerol® or barbituate.

4. Venesection using plastic tubing. Start dextran.

5. Calculate first 24 hours intake as follows:

a. Colloid solution 1 cc. per kilogram multiplied by the per cent of body surface burned (up to 50 per cent). Give 2 units of dextran to one of blood. Add antihistamine to blood transfusion.

b. Balanced electrolyte solution (travert® No. 1 or similar solution) 1 cc. per kilogram of body weight multiplied by the per cent of body surface burned (up to 50 per cent).

c. 5 per cent glucose in water, daily maintenance dose:

Patient's Weight (2.2 lbs./Kg.)	cc./24 hours
5 Kg.	400 cc.
10 Kg.	650 cc.
15 Kg.	850 cc.
20 Kg.	1,000 cc.
Adults	2,000 cc.

d. **Specify rate of intravenous fluid administration** in cc./hour.

6. Wide spectrum antibiotic given parenterally.

7. Levin tube with Gomco suction as indicated.

8. Tetanus toxoid or antitoxin.

9. Indwelling catheter.

10. Cortical steroid therapy is contraindicated except for severe shock that does not respond to adequate fluid therapy.

B. Management of the Acute Stage

1. Hematocrit every 6 hours for the first 48 hours, then daily for 3 days.

2. Maintain a urinary output of at least 30 cc. per hour for adults.

3. Vary speed and amount of intravenous fluids as indicated by 1 and 2.

4. In the second 24 hours give intravenous fluids in approximately half of the amount used in the first 24 hours.

5. Get a CO_2, chloride, sodium, potassium, and blood urea nitrogen determination on the second day; then every other day until patient is on oral fluids.

6. Give adequate intravenous fluid to keep the serum sodium level down and adequate parenteral potassium to keep the serum potassium level up. If on gastric suction replace aspirated fluid physiologically, volume for volume (with travert® No. 3 or similar solution).

7. When patient can take fluid orally, start with clear liquids to avoid distention.

8. Treat chronic diseases as necessary.

9. Observe for renal shutdown.

C. Long Term General Therapy

1. High protein, high calorie, six feeding diet vitamin supplement and oral iron.

2. Tube feedings as required. Add water as necessary to maintain hydration.

3. Get a blood volume reading weekly and plan to replace the deficit as you go along. Latent anemia shows up at 3 to 10 days. If adequate veins are not available and blood volume cannot be done, transfuse with whole blood once or twice a week to maintain normal blood volume.

4. Vary antibiotics as indicated. Sensitivity studies are inaccurate unless culture is taken from the depth of the wound. Keep acute staphylococcal enteritis in mind if fever, sore

throat, or diarrhea develop. In general, vary antibiotics weekly.

5. If tetanus antitoxin was used on admission, consider repeating in one week after skin testing again.

6. For critical general condition with no specific cause during this stage, consider a Thorn eosinophil test and base cortical steroid therapy upon the results.

IV. Care of the Burn Wound: Cleanliness and avoidance of infection, good general nutrition, early removal of devitalized tissue, and early resurfacing are fundamental to successful burn wound management.

A. Exposure Method: (Advantages: (1) Elimination of warm, moist environment conducive to infection, (2) Continuous observation and evaluation of wound possible, (3) Better dissipation of body heat, (4) Better pulmonary ventilation, (5) Early mobilization encouraged, (6) Economy of supplies, (7) Elimination of painful dressing changes.)

1. Initial treatment in Operating Room when burn is extensive.

2. General anesthesia not necessary.

3. Wash gently with hexachlorophene soap and saline on soft cotton pad.

4. Open blisters and debride devitalized tissue.

5. Place patient in bed with fresh linen (not necessarily sterile) over absorbent mattress pads. Cover with sheet.

6. Instruct patient in immobilization of joints and maintenance in positions of function.

7. Encourage patient to change position and to get up early, at least by the third day. For circumferential burns of trunk or extremities, the Stryker frame turned every four hours may be a great help.

8. Wash with hexachlorophene soap and saline on cotton pads daily or every other day.

9. Maintain high room temperature with steam kettle if necessary, for these patients are often chilly.

10. Debride devitalized tissue when possible and trim back the edges of the eschar on either side of cracks which may form.

11. Exposure method can be maintained no longer than 2 to 3 weeks, after which burn areas are either healed, grafted, or granulating.

12. Tub soaks and wet dressings when infection is present or when preparing for grafting procedures.

13. Closed and exposure methods may be combined, e. g., exposure of facial burn and dressing to the extremities.

B. Closed Method: (Dressings): (Advantages: 1. Relief of pain by splinting and immobilization, 2. Protection from infection, 3. Transportation simplified, 4. Avoidance of chilliness experienced by some patients with open method, 5. Easier handling of circumferential trunk burns, 6. Maintenance of joints in position of function.)

1. When burns are extensive, apply dressings in Operating Room.

2. General anesthesia not necessary.

3. Wash gently with hexachlorophene soap and saline on cotton pads.

4. Open blisters and debride devitalized tissue.

5. Apply a single layer of parachute silk or other fine mesh surgical fabric impregnated with furacin® ointment or a very thin layer of vaseline.®

6. Cover with a bulky absorbent padding.

7. Secure with elastic bandage, applied firmly, but not so tightly as to interfere with circulation.

8. Immobilize joints in positions of function with special care in placing metacarpal-phalangeal joints of hands in semiflexion.

9. Change dressings at 4 to 7 day intervals or as required for excessive drainage or infection. Soap and saline washes and debridement as indicated. Evaluate as to need and opportune time for resurfacing.

10. Closed and exposure methods may be combined, e. g., exposure of face burns and dressings to extremities.

C. Resurfacing areas of full thickness skin loss.

1. *Skin autografting.*

a. Primary excision of burn wound and immediate skin grafting can be done as emergency procedure in rare instances where burn is known to be full thickness, yet quite localized, as for example certain electrical burns.

b. As soon as burn areas are known to be of full thickness depth, they may be excised and skin grafted. The chemical debriding agents are costly and wasteful of time. Surgical debridement can be accomplished earlier. As soon as areas of full thickness burns are fairly well identified, sometimes as early as five days, grafting can begin. Early skin grafting before the patient is nutritionally depleted and the wounds complicated by infection can be more successful, greatly shorten convalescence, and minimize scarring and contracture which result from prolonged granulation, infection and healing.

c. Priority in early resurfacing should be given first to eyelids, secondly to hands, and thirdly to other joint areas.

d. Grafts should be placed so that their edges fall along natural skin creases. Grafts should be immobilized with sutures and covered with a layer of furacin® impregnated silk and a tie-on stent dressing. Dressings should be changed every 3 to 8 days.

e. With extensive burns donor areas should be conserved by careful planning and avoidance of technical errors with the dermatome. With very extensive burns thin split thickness

grafts (.006 to .008 inches in children and .010 to .012 inches in adults) should be used so that donor sites may be used more than one time.

f. Debridement should be more conservative in children and on the face.

2. *Skin homografting.*

a. In very extensive burns use of fresh cadaver skin is encouraged as a lifesaving measure. Live donors are satisfactory, but the supply of skin is limited.

b. Written, witnessed permission to be obtained from the burn victim and also from the nearest relative of the deceased donor. Both parties should have a clear understanding of the nature of the procedure, the reason for the homografts, and the temporary results anticipated.

c. Persons who have died from infection or malignancy are unsuitable donors. Skin donors must have a negative serologic test for syphilis. Blood type matching is not necessary.

d. A cadaver which has been properly refrigerated may be used as a skin donor within 24 hours of death.

e. Split thickness skin is removed from the cadaver with a dermatome in the Operating Room under sterile conditions.

f. Homologous skin may be preserved and used up to three weeks by folding it in saline moistened sponges which are placed in sterile jars and refrigerated at ordinary refrigeration temperature, (not in deep freeze). (It is well to add aqueous penicillin one million units and streptomycin 1 Gm. to 1,000 cc. of saline solution.)

g. Autografts and homografts should be alternated in covering large areas.

h. Successful skin homografts may remain viable for several weeks to several months. As they fail, they should be replaced by autogenous skin.

D. SPECIAL BURN PROBLEMS: The use of pedicle flaps, the treatment of burns of the eyeball, the management of exposed and burned tendon and bone, the repair of contractures and deformities, and other specialized problems are beyond the scope of this outline. Consultation should be requested early.

SUMMARY

An outline for the proper management of the severely burned individual has been presented. With wide distribution of the outline in the hospital, individuals and departments can prepare for the most effective handling of one or more burn cases. Although the outline provides a basis for therapy, it is important to observe the patient frequently and make necessary changes in therapy at once.

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* * *

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* * *

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* * *

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• NATURAL SWISS CHEESE has the highest value for vitamin B_{12} among the cheeses tested. The increase in this value of natural Swiss is believed to be due to synthesis of the vitamin by propionic acid bacteria involved in its manufacture.

* * *

• THE EVIDENCE to date indicates that infectious and serum viral hepatitis are caused by two different and unrelated viruses. Attempts to infect other animals with both of these viruses have failed.

* * *

• THE ASTHMATIC patient should be considered allergic to morphine, quinine, and sulfonamides until proven otherwise and these drugs always used with great caution.—J. F.

Trichobezoar: Survival Following Complication Of Perforated Ulcer

JAMES E. MULLEN, M.D.

BEZOARS of various kinds comprise a large percentage of the foreign bodies found in the gastrointestinal tract of man. Trichobezoars, or hair balls, account for about 53 per cent of these, but are infrequently considered as a pathological entity because of the abnormality of their origin and the almost universal denial by the trichophagic person. Gastric ulceration is an uncommon complication, and perforation of the ulcer is extremely rare.

DeBakey's[1] analysis found only 9.6 per cent of cases of trichohezoar associated with ulceration, and only 2.9 per cent perforated. His study in 1938 reported 177 cases of trichobezoar. A recent careful survey of the available literature up to the year 1955 has disclosed 39 additional reported cases,[2] bringing, so far as can be determined, the present world total cases to 211.* Of these surveyed cases only two were complicated by ulceration. Fox and Stiles[3] report that ulcers are found at operation in 15 per cent of cases.

In all, there have been, however, seven cases of trichobezoar complicated by perforation of an ulcer—only one of which was reported to have survived.[1, 4, 5] This paper will conclude with a report of the 212th case, and the second one to survive perforation of the ulcer.

HISTORY

Bezoars have been known since the twelfth century, and derive their name from the Arabic name "badzehr" or the Persian "padzahr," both indicating a healing or antidote power. Through time they have been highly valued for their power to fend poisons and cure a list of ailments; the stones found in a goat's stomachs particularly so. During the middle ages it was a highly profitable enterprise to counterfeit bezoars. However so, bezoars are simply concretions of various types found in the stomach of animals and man.

Trichobezoars are found too, in both animals and man, and are, of course, due to trichophagia. Baudamant is credited with observing the first case in a man in 1779, and Shonborn performed the first surgical operation in 1883 for this condition. With increase in diagnostic skill and surgical acumen, the incidence of trichobezoars seems to have advanced in recent years, but is yet so infrequent as to be a matter of great interest when found.

Other bezoars are phytobezoars, composed chiefly of vegetable fibers, seeds, skin of fruits etc., the persimmon seed said to be the most popular. There are also combinations of vegetable fibers, seeds and hair called trichophytobezoars, and others which are harder concretions, such as those formed by shellac in imhibing painters, and bismuth in individuals who have ulcers.

ETIOLOGY

How and why does hair get into the stomach? Animals may eat hair when normal dietary requirements are absent, or during their normal shedding periods. Meilchen experimentally fed hair to rats and to rabbits and demonstrated that trichobezoars do not exist by hair alone, but that the formation of a concretion was determined by the nature of the ingested food.

People eat hair, and usually their own, for a variety of reasons. Girls with long braids may chew the ends while preoccupied studying. Most trichobezoars (80 per cent) occur in the second decade of life. Extremes reported are the earliest in a one year old infant and the oldest in a 56 year old woman. By far the greatest majority (90 per cent) are found in women, presumably because of their greater hair length, nervous traits and psychotic tendencies. Trichobezoars may attain great size.

The incidence of this condition in mentally ill persons is surprisingly low, being about 14 per cent, but the repeat cases in patients who undergo surgical removal and then ingest hair again must certainly have a true psychotic etiology.

SYMPTOMS AND DIAGNOSIS

Trichobezoars seldom produce symptoms until they attain such a size as to intefere with nutrition, produce obstruction or ulceration, or may produce a notable palpable mass. Some cases may be suspected by the appearance of alopecia, but these are rare. Others may be found after

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*Ernst & Villaume mention a total of 317 cases described in the literature.

emesis of small hair masses. In general, however, the diagnosis is not made until the general signs of malaise, anemia, anorexia appear, and the complaints are vaguely referable to the gastrointestinal system. Even then, the diagnosis is not made until the patient is brought to the roentgenologist's table, where the mass is often expertly outlined.

Palpable masses and otherwise undiagnosed cases are often disclosed only after surgery. History obtained from the patient is not helpful, and direct question is often denied—although parental accusation may be the key. Of course, if one is known to be a hair swallower, there should be no problem.

Laboratory data are rarely helpful and it is unknown that any case was diagnosed by the appearance of hair in the feces. These hair balls

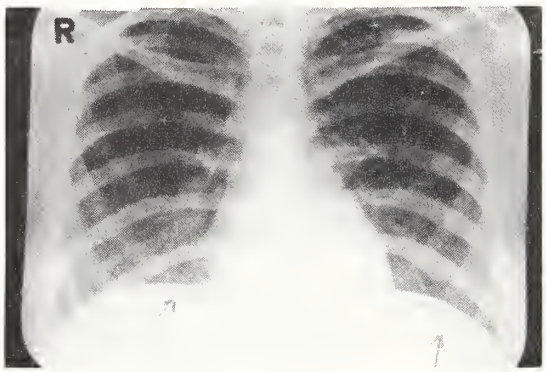


Fig. 1. Preoperative film showing air beneath both diaphragms.

go round and round in the stomach, and only sometimes extend a short distance into the duodenum.

Diagnosis depends on the ability of the physician to be aware of the possibility, especially in young girls with vague complaints. For such reasons this review is presented. The loss of desire for solid food, and the increase in appetite for liquid food is a clue. Some cases are diagnosed, as this reported one, only after surgery is undertaken for complications, such as gastric ulcer, gastric perforation, obstruction or hemorrhage. When trichobezoar is suspected or to be ruled out, the gastroscopic and roentgenographic procedures are of great value. Gastroscopic methods are usually not necessary and should only be done when fluoroscopic findings are inconclusive.

The criteria for x-ray diagnosis of trichobezoar has been established by Buckstein,[6] in that the shadow of the mass is centrally located so that the contours of the stomach are unaffected and can exhibit normal peristalsis. However, if the mass is so large as to occupy the entire stomach, peristalsis may be absent. The intragastric position of the mass may be shifted by manipulation under fluoroscopic vision. The mass may invaginate into the air bubble of the cardia, and hence stand out in relief. The stomach can be outlined by air interspersed in the interstices of the mottled hair on the plain film alone—as seen in retrospect in this case.

Ingestion of barium under fluoroscopic vision with the patient in the upright position is demonstrative of most trichobezoars. The barium stops momentarily at the cardia, then spreads throughout the fundus as it trickles over the surface of the hair mass, forming a mottled scene of streaks and bands fusing and separating, and finally revealing the entire stomach, but increased in size. Six hour films will show most of the barium has left the stomach, but some clings to the hair.

TREATMENT AND FINDINGS

The treatment of hair swallower's disease is to remove the hair ball. There seems to be no prophylaxis, for hair swallowers rarely admit. Surgical removal, therefore, is the sole means. Some small trichobezoars may be given up by emetic action but probably will not be known to our literature. The treatment of the second trichobezoar occurring in the same patient certainly demands the aid of a psychiatrist.

Surgical removal has a reported mortality of less than 4 per cent. No treatment—that is, no surgery—has a mortality of 50 to 70 per cent.[1] This high mortality is due to starvation, in-



Fig. 2. Preoperative prone film of the abdomen demonstrating the outline of the stomach and showing small fragments of metal.

testinal obstruction, ulceration with perforation and hemorrhage.

The stomach, when opened by whatever means dictated by the size of the mass, gives forth a foul and fetid odor. The hair mass may be small, or large enough to occupy the entire stomach, or may be composed of multiple balls. It is dark brown to black in color and has the consistency of thick felt. When grasped with instruments it tends to shred off in bunches. Only towel clips or large tenaculae give firm holding. Closure of the stomach should not be done until satisfied there are no remaining hair balls, or "tails" extending into the duodenum.

The size and weight varies. Reported are cases in terms of dry weight and wet weight. The largest reported was 6½ pounds. In drying, the hair ball may lose as much as 60 per cent of its original weight. The measurements of the largest reported specimen were 15 by 17 by 8½ inches.

Complications, as ulceration, are treated in the usual surgical manner and postoperative care is as for any gastric case.

REPORT OF CASE

The patient, Miss , age 17, was seen at 1:30 p. m. shortly after admission to St. Charles Hospital, Toledo, complaining of severe cramping pain in the central and upper left abdomen for 48 hours. She stated that the pain began as a generalized abdominal cramping and was ascribed to menstrual origin, although higher and more severe. In the four hours before admission, the pain began to localize to the epigastric area, and became exceedingly intense.

Relevant family history revealed that the father had been operated upon for gastric ulcer.

There were no significant revelations in the



Fig. 3. Trichohezoar.

patient's past history. The review of systems was sparse except for the mother's contributions that the patient, for the past several weeks, had preferred liquids instead of solid meals and more often declined eating, stating that she was not hungry. As a rule the menses were accompanied by only mild to moderate discomfort.

On physical examination there was presented a young adult, of normal development and nourishment, and in severe pain. The temperature was 101°F; pulse 130; respirations 30; blood



Fig. 4. Postoperative film showing residual mucosal thickening of the stomach.

pressure 100/60. The positive findings were extreme tenderness over the mid-epigastrium and upper left abdomen with marked muscle rigidity throughout the upper areas. The tentative diagnosis was peritonitis due to a possible perforated ulcer. The laboratory gave normal urine findings. The blood picture was red blood cell count, 5,800,000; white blood cell count, 13,250; hemoglobin, 13.6 Gm.; stab forms, 13; segmented, 66; lymphocytes, 21.

At 2:00 p. m. upright plain films of the abdomen and chest showed a "definite evidence of free air beneath both diaphragms. The colon is moderately dilated. The stomach can be outlined and there are small pieces of metal within this gastric shadow. The findings indicate a ruptured perforated hollow viscus, most likely stomach or duodenum. The heart and lungs are normal in appearance." (JWS)

After suitable preparation, at 5:00 p. m., the abdomen was opened through an upper transverse incision. The omental structures were highly edematous. There was very little free fluid in the upper abdominal cavity. The stomach was greatly enlarged and formed a hard firm mass from the gastric cardia to the pylorus. There was a small pinpoint perforation on the anterior surface, midportion of the stomach. This ulcer bearing area was excised and the defect closed.

The stomach was opened by a transverse incision in the pre-pyloric area, extending from lesser to greater curvature, disclosing a large mass composed of black hair and foul-smelling viscid substance which occupied the entire stomach. The mass was grasped by a tenaculum forceps, the smaller pyloric portion being delivered first, then the entire mass removed. This trichobezoar had a tail extending about 4

inches into the duodenum. When the determination had been made that there were no more hair masses or strands in the stomach or duodenum, the stomach was closed with two layers of suture. The abdomen was closed in the usual manner with soft rubber drains emerging at either end of the incision.

This trichobezoar was a perfect cast of the stomach and had a wet weight of 7 pounds. Its measurements were 21 by 15 by 8.5 cm. The Pathology Department report was: "Chronic ulcer of the stomach with perforation; acute fibrinous peritonitis; trichobezoar of the stomach."

SUBSEQUENT X-RAY STUDIES

On the fourth postoperative day, on barium fluoroscopic examination, the stomach appeared to be normal in size and of normal tone. No essential abnormalities were noted fluoroscopically. On the 11th postoperative day, barium stomach recheck showed the gastric mucosa markedly thickened along the lesser curvature of the body of the stomach. No ulcer crater was demonstrable. The mucosa along the lesser curvature was thickened to the extent that it simulated polypoid filling defects.

Barium emptied readily through the pylorus, and the duodenal bulb was regular in outline. The second and third portions of the duodenum were normal. At the end of four hours, the stomach was empty and the barium had reached the distal small bowel, showing normal motility.

A barium enema examination was reported: "The colon filled readily, without obstruction. The colon was redundant. On evacuation, emptying of the colon was rather poor. There appeared to be some loss of tone of the colon present. No abnormalities were noted and there was no evidence of any foreign bodies in the colon or in the region of the cecum. The terminal ileum filled and showed no abnormality." (JWS)

SUBSEQUENT COURSE IN THE HOSPITAL

The patient exhibited some mild psychotic tendencies in the early postoperative days, such as condemning herself for getting out of bed at night, but refusing to ambulate in the daytime. She removed her Levin tube "by accident" on the fourth day and was deeply self-critical for this action. However, by the fifth day, with the establishment of oral feedings, she rapidly returned to a normal, cheerful postoperative patient. It is notable that the Levin gastric drainage during the first 48 hours was remarkably foul.

During the remainder of her hospital stay, she was a cooperative patient. She was discharged to the care of her family physician on the twelfth day and has been well since. When the parents were advised of the operative findings, the mother readily admitted that the girl had been eating her braided hair ends since early childhood.

SUMMARY

A review of the subject of trichobezoars, and a case of perforated stomach as a complication of trichobezoar is presented. A recent review and total of the reported cases is included. Roentgenographic findings are given in detail. This is the second known case to survive following perforation of the stomach.

CASES REPORTED TO 1955

1938—DeBakey 172; Allen 1; Webster 1; Rodrequiz Castro 1.
1939—Gabystan 1; Collins 1; Butters 1.
1940—Nemec 1.
1941—Sumney & Borzel 1.
1942—Levey & Smith 1; V. C. Harris 1.
1943—Lear & Brady 1.
1944—Batygina 1; Graberger 1; Miller & Kurt 3.
1945—Clayton-Mitchel 1; Sarnoffs 1.
1947—Watt-Horner 1; Sturlese 1; F. M. Parsons 1; Amendie & Giovanardi 1.
1948—McCrae 1; Bracci & Moraca 1; Nussy & Leaske 1; Peake 1.
1949—Azueta Gonzalez 1; Nelson & Colvin 1; DeLeeuw 1; Sawyer, Coppinger & Nelson 1.
1950—Wilkinson 2; Ernst & Vallaume 1.
1951—Fox & Stilles 1; Osmond & Price 1; Hurwitz & McAlenny 2; J. M. Bertran, Jr. 1.
1954—Friedlander & Kushlik 1.

Total: 211

Acknowledgements: Credit is given to the family physician, Dr. Reynold A. Tank of the St. Charles Hospital staff for his fine cooperation in the care of this patient and permission to present the case. To Dr. John W. Symthe, director of the Department of Radiology for his cooperation in the patient's care and aid in preparation of this manuscript. To the Toledo Academy of Medicine Library for much aid in research.

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Upper Extremity Examination in The Evaluation of Grip Loss

The evaluation of grip loss is a medical problem involving many factors. . . . The following should be reported in every upper extremity examination, made for rating purposes:

1. Dynamometer readings of injured and uninjured sides.

2. Girth in inches of both arms and both forearms.

3. Complete comparative measurements of each joint of the extremity, unless it can be stated that measurement has shown the joint range to be equal to the opposite normal.

4. Distance in inches which the finger tips miss the midpalm.

5. A description of any preexisting grip loss of the injured extremity.

6. A description of any preexisting grip loss of the opposite extremity, together with the examiners estimate of what the normal grip should be. (Refer to items 1 and 2.)

7. A statement regarding which is the major hand.—John E. Kirkpatrick, M. D., San Francisco: *California Medicine*, 85:314, Nov., 1956.

Local Injection of Prednisolone TBA in the Treatment Of Rheumatic Diseases

NORMAN O. ROTHERMICH, M.D., and VOL K. PHILIPS, M.D.

THE beneficial effects of intra-articular injection of hydrocortisone acetate, first introduced by Hollander in 1951, is well known to all physicians treating arthritis.[1] Since the introduction of oral prednisone and prednisolone in the treatment of the systemic manifestations as well as the joint manifestations of rheumatic disorders, suspensions of the latter agents have been used for intra-articular injections in the hope that their effects would be superior to those of hydrocortisone. Suspensions of prednisone, like its analog cortisone, have proved ineffective in intra-articular injection therapy of inflamed joints. Following is a study of the use of prednisolone tertiary butyl-acetate (deltra-1 dehydro-hydrocortisone tertiary butyl-acetate)* as definitive treatment for a variety of articular or periarticular disorders.

This study covers the experience with the use of prednisolone TBA intra- or extra-articularly in 35 patients with active arthritic disorders seen during the first five months of 1956. Patients were selected on the basis of the primary complaint of pain in one or more joints or periarticular areas. In a few instances, patients whose primary complaint was stiffness or immobility of a joint were included. All patients had either rheumatoid arthritis in an active stage, fibrositis, or osteoarthritis. Where osteoarthritis or fibrositis coexisted in a patient with rheumatoid arthritis, the patient was considered as having rheumatoid arthritis as the primary disease.

All patients were begun initially on base-line symptomatic therapy consisting of salicylates and mild barbiturate sedation. In many instances, where there was multiple joint involvement with active rheumatoid arthritis or where systemic activity was manifest, the patient was on additional metisteroid therapy in the form of prednisone or prednisolone, 5 to 20 mg. daily. In no instance was intra-articular injection therapy initiated until maximal early benefit had been received from general systemic therapy.

TECHNIQUE

Simple aseptic precautions without the use of drapes or rubber gloves were used in all instances. No local anesthesia was used. Doses injected varied from as little as 2.5 to 5 mg. (1/8 to 1/4 cc.) for interphalangeal joints, to as much as 20 to 40 mg. (1 to 2 cc.) for larger joints such as the hip or knee. Contrary to Hollander's experience, we have found that where point tenderness was elicited in periarticular tissues outside the joint capsule that injection into this area was more likely to provide relief from pain than intra-articular injection.[2]

Submitted July 23, 1956.

*Prednisolone TBA used in this study was supplied by Elmer Alpert, M. D., of Merck & Co., Rahway, New Jersey.

The Authors

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● Dr. Philips, Columbus, staff physician at Columbus Medical Center, is instructor in medicine, Ohio State University College of Medicine.

RESULTS

The results after injection ranged from no improvement to complete remission lasting longer than four months. In a few instances, relief from pain began within a few hours after injection. In most patients, however, relief from pain and increase in mobility occurred approximately 24 hours after the intra-articular injection. In this series, no temporary increase in inflammation was seen. As has been the case with hydrocortisone acetate, repeated intra-articular injections of prednisolone TBA tended to exceed the degree and duration of initial alleviation.

For purposes of evaluation, remissions in pain and stiffness have been divided into those receiving less than four weeks benefit after one or more injections, and those receiving greater than four weeks benefit after similar injection or injections.

Of 27 patients having active rheumatoid arthritis or periarticular fibrositis given intra- or extra-articular injections into 45 sites, 22 showed beneficial effect and five showed none. Of eight patients with osteoarthritis in whom 13 sites were injected, all showed remissions. Contrary to the experience with hydrocortisone, the majority of patients receiving any benefit from prednisolone

TBA injections had remissions in pain and stiffness lasting longer than four weeks. (Table 1)

TABLE 1.—PREDNISOLONE TBA
All patients, all sites, intra- and extra-articular

	Remissions		
	> 4 wks.	< 4 wks.	None
RA, fibrositis (27-45)*	14	8	5
Osteoarthritis (8-13)	5	3	0
Totals (35-58)	19	11	5

*In this and succeeding tables, the first figure in parentheses indicates the number of patients treated. The second figure represents the total number of sites injected, irrespective of the number of injections given any one site over a period of time.

Patients receiving intra-articular injection only of prednisolone TBA were 23 in number. Seventeen patients with rheumatoid arthritis received one or more intra-articular injections into 32 sites. Fourteen of these showed temporary remissions, and in three patients there was no beneficial effect. In all six patients with osteoarthritis, intra-articular injection of prednisolone TBA proved of lasting benefit. (Table 2)

TABLE 2—PREDNISOLONE TBA
Intra-articular injections only

	Remissions		
	> 4 wks.	< 4 wks.	None
RA, fibrositis (17-32)	9	5	3
Osteoarthritis (6-9)	4	2	0
Totals (23-41)	13	7	3

Fibrositis is a difficult disorder to define since it may co-exist with an articular disorder or exist alone. Where the complaint of pain or stiffness was distinctly of periarticular origin, extra-articular injection into the area of greatest tenderness was used exclusively. Of 12 such patients with single or multiple areas of fibrositis with or without articular disease, 10 showed definite beneficial effect from one or more injections; two showed no benefit. (Table 3)

TABLE 3.—PREDNISOLONE TBA
Extra-articular injections only

	> 4 wks.	< 4 wks.	None
Fibrositis:			
Single, multiple, with or without articular disease (12-17)	6	4	2

That intra-articular injection of prednisolone should prove a useful adjunctive treatment in the management of patients with articular and periarticular disorders was predictable from the similar effect of hydrocortisone. It would appear, however, that prednisolone TBA produces a longer lasting remission in pain and stiffness when given intra-articularly than does its structural analog, hydrocortisone. It would appear that the prolonged effect of prednisolone TBA injection is accomplished with approximately the same dosage milligram for milligram and volume of injection as with hydrocortisone acetate. The beneficial effect sometimes encountered with the periarticular injection of prednisolone TBA into sensitive areas adjacent to joints having active intra-articular disease requires further study.

SUMMARY

Thirty-five patients with active rheumatoid arthritis, fibrositis, or osteoarthritis have received one or more intra-articular injections of prednisolone TBA into a total of 58 sites. Of these, 19 patients had a remission in pain and stiffness in the injected joint for four or more weeks; 11 had remissions lasting less than four weeks; five had no response. From our studies, prednisolone TBA produces beneficial effects in the local treatment of rheumatic disorders exceeding that of its structural analog, hydrocortisone acetate. No adverse effects have resulted from intra-articular injection of prednisolone TBA.

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Interpretation of the Routine Blood Count

One concept which arises occasionally is the distinction between relative and absolute variations in numbers of certain types of leukocytes. In a patient suspected of a viral infection such as infectious mononucleosis, a high normal leukocyte count of 10,000 assumes significance if we realize that the lymphocyte percentage of 50 per cent indicates not only a relative lymphocytosis, but an absolute increase in the numbers of circulating lymphocytes. In a patient with a bad sore throat and a leukocyte count of 4,500 and a differential showing 50 per cent lymphocytes and 50 per cent granulocytes we become much more alarmed if we realize that this is an absolute granulocytopenia and only a relative lymphocytosis.—Keith Truemner, M. D., Rockford: *Illinois M. J.*, 110:177, October, 1956.

The Cry of Infants

Illness is of no concern to the infant, but discomfort and pain are. When hurt it can use only the universal language of all newborn people—the cry. . . Although it is impossible to measure an infant's complaint by the strength of its cry, one can get a fairly good idea of the reality of pain by listening to the wail itself. Beware of being led astray, however, by the child who is too sick to cry. The infant who looks sick but merely whimpers is in danger. A lusty cry is an indication not only of a normal response to pain, but also of plenty of reserve strength to combat the existing ailment.—W. J. Potts: *Surg. Clin. North America*, February, 1956, p. 93.

Clinical Observations with a Nystatin And Fluorohydrocortisone Ointment

ROY L. KILE, M. D.

NYSTATIN (mycostatin® Squibb) is an anti-fungal antibiotic derived from cultures of Streptomyces noursei. It has been found to have antagonistic action on many species of yeasts and a few molds but to have limited or no effect on bacteria, protozoa or filterable viruses. It is particularly effective against Candida albicans, which organism is employed for test assay.

As is generally known this antibiotic, when given orally, has a suppressive effect on the growth of Candida albicans in the intestinal tract. It has also been used for these monilial infections in the mouth, vagina as well as on the skin. It is particularly in this latter field that the following clinical report is concerned. As is generally known by clinicians monilial infections are most stubborn. Previous to the availability of this antibiotic, we have had considerable difficulty in their management.

Much previous work has established the effectiveness of fluorohydrocortisone applied topically in strength of 0.1 to 0.2 per cent. It was felt that a combination of this fungicidal antibiotic with the anti-inflammatory effect of this steroid might be a most valuable preparation to have at one's disposal in the management of these topical infections. As a result a series of cases on which this preparation might be of value were observed. The preparation* used contained (nystatin) 100,000, units per gram, along with 0.1 per cent of fluorohydrocortisone in a plasticized hydrocarbon gel as an ointment base. This latter preparation is known as plastibase.®

The accompanying chart presents some of the results of its use. A total of over 100 patients were observed. The conditions on which it was most effective soon accumulated the largest number in the series. It will be observed that one patient was irritated by nystatin ointment alone but when combined with fluorohydrocortisone it did not irritate. Two patients in the series felt that the ointment made their skin condition more red and caused some burning. No true sensitivity was demonstrated but it was interesting that the 0.1 per cent of fluorohydrocortisone present did not prevent irritation in these two patients. It apparently did in several others, however.

Submitted February 10, 1956.

*Kindly furnished for me from the Squibb Laboratory for Medical Research by Drs. Harvey Blank and Gavin Hildick-Smith.

The Author

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The two diabetics in the series who had moniliasis in the folds of their body did very well on this preparation. Probaby its most striking effect is in certain cases of tinea cruris where there was considerable irritation. Certain cases of pruritus ani that had been present for a long time found considerable relief from this ointment. This was also true with certain cases of intertrigo and otitis externa. In the latter condition at times the effect was most striking. While there are only four cases in this series, it had a more dramatic effect here than almost anywhere else.

COMMENT

Nystatin ointment is indicated for the treatment of certain cutaneous mycoses particularly those caused by Candida albicans (moniliasis). This includes monilia paronychia, moniliasis in the diaper and intertriginous areas as well as the cutaneous and muco-cutaneous manifestations of a generalized monilia infection. It is in this realm that the ointment finds its most effectiveness.

At times the use of the nystatin ointment alone has been a little discouraging. However, on the combination with fluorohydrocortisone many of these cases (who did not do well previously) were found to be benefited. Obviously a 0.1 per cent fluorohydrocortisone ointment alone should have been used as a control. Undoubtedly a number of the cases would have done well with only this preparation. However, the addition of the nystatin certainly enhanced its effect in the management of certain intertriginous infections. By much previous experience with fluorohydrocortisone ointments and lotions there were not the consistent results found with this combination in these types of infections.

The results on monilia paronychia were slow as would be expected, but inflammation gradually subsided and the nails slowly grew in normally.

TABLE 1.—NYSTATIN WITH FLUOROHYDROCORTISONE OINTMENT

Diagnosis	Number of Cases	Length of Use	Markedly Improved	Improved	Same	Irritated	Remarks
Pruritus ani	12	2-4 Wks.	10	2	....	....	.....
Diaper dermatitis	3	3 Wks.	1	2	....	....	.....
Paronychia	4	2-3 Mos.	1	2	1	....	.....
Epidermophytosis	12	3-4 Wks.	1*	8	2	1	*nystatin irritated ; this did not
Intertrigo	16	1-8 Wks.	9	6	....	1*	*says made area red and burn
Onychomycosis	3	2-3 Mos.	....	3	....	....	.....
Eczematoid dermatitis	16	1-3 Mos	1	9	5	1*	*says made area red
Dyshidrosis	3	2-8 Wks.	1	2	....	....	.....
Tinea corporis	2	2-8 Wks.	....	2	....	....	.....
Tinea cruris	22	1-6 Wks.	14	7	1	....	.....
Otitis externa	4	2-6 Wks.	3	1	....	....	.....
Psoriasis	2	2 Mos.	....	1	1	....	.....
Seborrheic dermatitis	2	1 Mo.	....	1	1	....	.....
Moniliasis	3	1 Mo.	2	1	....	....	2 had diabetes
Erosio blastomycetica interdigitale	2	1-2 Mos.	1	1	....	....	.....
TOTAL	106		11	48	11	3	
				87%			

At times other fungicidal liquids were used simultaneously, making it impossible to be sure that all the effect was the result of this ointment. The results nonetheless were much better when the combination was used. Pruritus ani deserves special mention. Certain cases where there was considerable maceration in the perianal area showed rather dramatic results using this combination of chemicals.

Epidermophytosis and other types of fungus infections did only fairly well with this preparation. It has been previously shown that mycotic infections caused by organisms other than Candida albicans, did not do too well with this antibiotic. Probably most of the effect was the result of the anti-inflammatory action of the steroid present. It is not recommended that this ointment be used regularly in the treatment of epidermophytosis. This same applies to tinea corporis and tinea capitis. The latter disease was not included in this chart but it was tried on a few cases without effect.

There has been some feeling among a few investigators that topical use of steroids might stimulate local infections both with bacteria and fungi. This certainly has not been the author's experience with the topical use of any of the steroids. However, this combination should overcome this objection if there be one.

SUMMARY

(1) A series of 106 patients who had used an ointment containing nystatin with 0.1 per cent fluorohydrocortisone were observed.

(2) This preparation was found most effective in the management of monilia infections that occurred in the folds of the body. Its effectiveness was equally as good for many cases of pruritus ani and otitis externa.

(3) For other fungus infections the results were certainly not sensational and perhaps it should not be employed in their management.

(4) The preparation is recommended for use in monilia infections of the skin. The presence of the fluorohydrocortisone certainly enhances its effectiveness and increases the value of nystatin as a topical agent.

The Relation of Diet To Atherosclerosis

Of the many causal factors in the pathogenesis of atherosclerosis and coronary artery disease an abnormal serum lipid complex reducible by dietary means has recently been implicated. Since this abnormal complex is significantly increased in only certain individuals, dietary regulation of ingested fat may be beneficial only in those certain individuals.

The abnormal serum lipid complex has been assumed to involve triglyceride-rich beta-lipoproteins of low density. However, the extent of their presence in postabsorptive sera is interrelated with the amount of triglycerides, elevations of cholesterol or of the cholesterol-phospholipid ratio. An increased alimentary lipemia may be another manifestation of this abnormality, and possibly, through its influence on the clotting mechanism or on cholesterol deposition, may be the factor immediately responsible for some cases of coronary thrombosis.

Restriction of dietary fat, substitution of unsaturated vegetable and fish oils for saturated dairy and animal fats, and stimulation of carbohydrate metabolism are discussed as factors which may improve the serum abnormalities.—Margaret J. Albrink, M. D., and Evelyn B. Man. Ph. D., New Haven: *Connecticut State M. J.*, 20:974, December, 1956.

The Status and Progress of the Receiving Hospitals In Ohio

EUGENE E. ELDER, M.D

THIS is the third and final summary of a series of articles published in *The Ohio State Medical Journal*, entitled: "The Purpose of the Receiving Hospitals." The two previous articles were published in volume 46, March, 1950, and volume 47, June, 1951.

Since a decade has passed in the history of the receiving hospitals in Ohio, this may be considered the appropriate time to summarize the accomplishments of this type of institution.

The Woodside Receiving Hospital was the first of such hospitals to be established, and statistical data compiled during this period are believed to be sufficient to indicate the value of this type of hospital, in treatment, betterments and results. Other than the first year of operation, the admissions at Woodside Receiving Hospital have been the highest in the State, including the large state hospitals. For instance, admissions to Woodside last year were 1282, compared with 598 for Massillon State Hospital.

Of the 1282 admissions, 72 per cent were voluntary. This has been the general pattern during the past 10 years. The number of home improved patients is generally about 75 per cent, although the rate has been up the past two years from 79 to 81.4 per cent. During the same two year period, the improvement of first admission patients was 86 per cent; readmissions were up from the normal 14 to 16 per cent to 22 to 24 per cent. The number of commitments to the Massillon State Hospital was about 8 per cent, somewhat less than previously.

The capacity of the six independent receiving hospitals is 1060 beds, of which only 773 were occupied as of April 30, 1955. These six receiving hospitals are: Ohio State University, Summit County, Woodside, Portsmouth, Rollman, and Cleveland Receiving Hospitals. The full value of these hospitals to the communities they serve will not be realized unless and until their facilities are put to use to the maximum. This would require a near capacity residence, and almost constant turnover, and tend toward an average stay of 46 days.

The Woodside Receiving Hospital has a 200 bed capacity, with an average census of 165 patients; however, at times we approach capacity with 190 patients. While during the past year the average stay was 46 days, the average was considerably less during the previous years. It should be pointed out that in order to achieve a high improvement rate in the period of 46 days, receiving hospitals must be completely staffed with doctors, nurses and attendants, according to American Psychiatric Association standards.

Our nurse and attendant ratio is one to six, and one to five, whereas it should be one to five, and one to four. In this respect we are regretfully a little short of the A. P. A. requirements. At present we have 28 nurses and 32 attendants for an average of 165 patients. This personnel is, of course, divided into three shifts. Our doctor ratio is 1 to 35, including consultants and part time physicians.

TYPES OF TREATMENT

The important factor as far as patients are concerned is immediate treatment, whether such treatment is electric, insulin, alcoholic or other type. Most cases do not require permits from the patient or his family since our voluntary admission form permits us to administer any form of treatment we feel may benefit the patient. This is a very valuable procedure. It is only in those rare cases where physical illness increases the hazards of such treatment that permits are requested.

In addition to active treatment, we have performed about 100 lobotomies during our 10 years; about 70 were small transorbital lobotomies, the balance were modified Freeman transorbital lobotomies. In our opinion, the last type of lobotomy effected the better results; close to 75 per cent home improvement. There were no complications of epilepsy, hemorrhage, etc.; this operation is considered safe.

RATE OF IMPROVEMENT

The high improvement rate of first admissions, as indicated by the foregoing statistics, should be noted. The increase of readmissions is justified by the fact that as the years pass, the number of patients released from the hospital grows steadily, thereby providing more discharged patients to draw from. Naturally, the misfortune of mental disease is such that patients are subject to possible relapses at any time on the smallest provocation. Since it is impossible in most instances to change the patient's environment, he will be subject to the same stresses, the same apprehensions, and the same job difficulties as previously.

To remedy this situation as much as possible,

The Author

● Dr. Elder, Youngstown, is superintendent of Woodside Receiving Hospital.

Presented before the Section on Nervous and Mental Diseases April 10, 1956, at the Annual Meeting of the Ohio State Medical Association, Cleveland.

we feel that it is a vital necessity that a well oriented psychiatric social worker go into the homes of patients to determine the various situational problems, to advise and guide the family. Another remedy we expect to employ is an independent Outpatient Department. This will include the services of a doctor, nurse, psychologist, social worker and a clerk. It will be in the same building but will have no contact with inpatients; there will be a separate entrance and facilities. This will give the staff more time to concentrate on individual care of inpatients.

DRUG THERAPY

The use of thorazine® and serpasil® has also proved successful during the past eight months, especially in the milder type of anxieties, ambulant and outpatients with some restlessness, sleeplessness, and some prepsychotic conditions; 10 to 25 mg. three times a day proved to be very helpful; however, the more serious type of inpatients receive up to 1,500 mg. per day. As to the more serious and depressed types, we still use courses of electric treatment. To effect a more quiet ward, and avoid restraint, thorazine® has been very helpful; it has also been useful when withdrawing drugs from addicts and for the same purpose when alcoholic.

It is only in recent years that public awareness of the mental problem has made progress possible. However, here in the State of Ohio, in spite of the progress made since the establishment of receiving hospitals 10 years ago, we still have not touched the root of the trouble. We have not had enough buildings, doctors or scientists to tackle the increasing growth of mental illness. Dr. John D. Porterfield, Director of Ohio Department of Mental Hygiene and Correction, has established three research and teaching institutions, in Cleveland, Columbus and Cincinnati.

Each of these institutions is connected with a university medical school where residents and doctors will be trained to supply the demand in the state for adequately trained doctors, taught in the modern and dynamic treatment of mental patients. Such doctors, however, tend to gravitate toward the larger cities, not toward hospitals in smaller communities which are without university medical school affiliation, such as Woodside and Summit County Receiving Hospitals.

In the future, this program will give these small hospitals more opportunity to secure the services of new and adequately trained physicians. Until such time as this can be accomplished, we should have a research man, with the necessary background, visit our smaller hospitals once a month and give the staff some ideas of new developments and research subjects. It is felt that within a few years this will show results; small hospitals will be better staffed and will do even better work than today.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met at the Columbus Health Center on October 17, at 12 noon. Three cases were presented.

Case 33: A 78 year old white female noticed a lesion on her vulva in January. Report from biopsy of lesion was squamous cell carcinoma of the vulva. Only a wide biopsy of the lesion was done. Lesion recurred one year later and a wide biopsy was again done. There was recurrence the next year and the patient was given external therapy. After three years, the lesion continuing to progress, a third biopsy was done and a second course of external therapy was directed to the lesion. Pelvic examination today revealed an infected punched out area in the left labia majora approximately 1 cm. There was massive edema of the left labia majora. Patient admitted to the hospital.

Comments: DR. HARRY E. EZELL: Patient delay is negligible. Delay of five years while the physician was carrying out inadequate treatment.

DR. JOHN H. HOLZAEPFEL: A radical vulvectomy is recommended in this case. If cancer were to be made a reportable disease such as the communicable diseases, then this sort of therapy could be prevented.

Case 34: A 36 year old white female first noticed vaginal discharge and bleeding in the Spring. Reported to her physician in August. Admitted to the hospital and found to have carcinoma of the cervix, Clinical Stage III. Treated with radium, 5,000 milligram hours followed by external radiation. In February, the next year, she began to have pain. Examination revealed extension of the mass to one side of the cervix with extensive and deep ulceration. Due to uncontrollable bleeding, a bilateral extraperitoneal hypogastric artery ligation was done. Patient's course has been steadily downhill and when last seen in September she was in terminal status.

Comments: DR. HARRY E. EZELL: Patients can't wait for appearance of symptoms. For adequate and prompt treatment they must have periodic pelvic examinations.

DR. EDWIN ZARTMAN: Patient delay of five months.

Case 35: A 48 year old colored female entered hospital because of lower abdominal pain and weakness. Noticed vaginal bleeding in January. Three months later she consulted her physician who recommended admission. (Twelve years prior the patient had a subtotal hysterectomy and right salpingo-oophorectomy.) Diagnosis on admission was carcinoma of the cervical stump. She was treated with radium, 4,800 milligram hours and vaginal x-ray, 4,000 r. In January, three years later, she had far advanced carcinoma and her course was steadily downhill. She received another course of external therapy, 5,500 r., but in spite of this treatment, she expired in June.

Comments: DR. FRANKLIN HUGGENBERGER: Patient delay of three months.

DR. JONATHAN BUSBY: Treatment was inadequate in that subtotal hysterectomy was done without careful follow-up.

Maternal Mortality and the Role of the Local Health Department in Prevention of These Deaths*

ANTHONY RUPPERSBERG, JR., M. D.

IT IS paradoxical that in spite of the progressive increase in the life expectancy of our population in the United States, still many deaths, a majority of which are preventable, continue to occur in one important and isolated group of society—women in the child-bearing years of life. Although the maternal mortality rate has diminished appreciably in the past decade at the local and national level, we feel that it is still imperative to further reduce the rate to an irreducible minimum. Towards this goal, maternal mortality study committees have been organized at county society levels,[2, 3] and several years ago at state level by the Ohio State Medical Association.[3]

To bring the matter into closer focus, let us examine several statistics from the State of Ohio. In 1955, there were 222,689 live births in Ohio[1] with 88 maternal deaths. These figures are quite accurate, since they have been tabulated from birth and death certificate forms on file in the Division of Vital Statistics. Yet it is reasonable to assume that some maternal deaths escaped inclusion in the statistics, if the physician failed to include pregnancy as a related cause in the contributory causes of death, when he completed the death certificate. In comparison, there were 222,266 live births in Ohio[1] in 1954, with 99 maternal deaths. Furthermore, if we examine the comparative number of stillbirths for the two respective years (Table 1), it is apparent that we should seek to improve the maternal, perinatal, and child health conditions of Ohio, in a worthwhile project.

TABLE 1. LIVE BIRTHS, STILLBIRTHS AND MATERNAL DEATHS IN OHIO, 1954-1955

Ohio	1954	1955
Live Births	222,266	222,689
Stillbirths	3,733	3,736
Maternal Deaths	99	88

The approach to the problem of improving maternal health in any given area must follow a sound and carefully planned program. The maintenance of a maternal mortality study which aims to continue for years must utilize a well coordinated organization whose various members function with the precision of a perfect team.

As Health Commissioners of our great state of Ohio, you have been recognized as very important members of the "team" which has been organized to protect "Maternal Health in Ohio." A graphic organizational chart (Fig. 1) depicts the close liaison maintained between the Committee on Maternal Health (Ohio State Medical Association) and the Ohio Department of Health, as well as a close coordination between the local medical society and the local county and city health departments, in respective districts and counties in Ohio.

We believe it is quite appropriate at this point to acknowledge with appreciation, the continued cooperation and assistance which the Committee on Maternal Health (Ohio State Medical Association) has enjoyed from Dr. Ralph Dwork (Director of Health, Ohio) and members of his department, in particular Dr. Margot Hartmann, Chief of The Child Hygiene Division. This is also an excellent opportunity to note and acknowledge the endless cooperation and help which members of the Franklin County Maternal Mortality Study Committee have received in the initiation and maintenance of the county study during the past eight consecutive years of its operation from Dr. Ollie Goodloe (Columbus Health Commissioner).

Before we discuss the prevention of maternal deaths in Ohio and the respective roles to be played by members of the team in the negotiation of this goal, let us briefly survey several "rules of the game," or terminology, as we say in medical parlance.

There has been considerable variation in defining certain medical terms among maternal mortality studies operated in 44 of the 48 United States. Presently various committees and subcommittees mentioned by Ott and Longyear[4] have sought to solve these and other problems connected with uniformity among all studies, in order that a common language might make the

*Presented at the Thirty-Seventh Ohio Health Commissioners Conference, Columbus, Ohio, September 27, 1956.

The Author

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data of various projects available for evaluation, without irregular interpolation.

To this end, the adoption of a usable list of terminology and nomenclature for the "state study" was part of the early planning of the (state) Committee on Maternal Health. This information, along with basic principles and an outline of the study, has been published[3] previously.

MATERNAL CASE

If death occurs in a woman, in the State of Ohio, who is in a state of pregnancy or within 12 months (one year) following the date of termination of her pregnancy, regardless of the length of gestation, her case is included in the maternal mortality study as a "maternal case."

MATERNAL DEATH

Data on maternal cases are compiled, and after final study and appraisal, each case is classified by the Committee on Maternal Health as a *maternal death* or a *non-maternal death* (non-obstetric death).

The term *maternal death* is applied to include all deaths in women with either a non-viable or viable fetus, dying during pregnancy, labor or the puerperium from causes directly due to the pregnant state, such as abortion, ectopic pregnancy, placenta previa, etc., as well as associated causes such as heart disease, embolism, tuberculosis and other accidental complications of pregnancy but not necessarily limited to these alone. Exclusion of the non-maternal (non-obstetric) deaths is accomplished by a simple majority vote of the Committee at its regular meeting. The term "non-maternal" has been adopted for use in the study in preference to the term "non-obstetric" since it follows the International Statistical Classification[5] and, furthermore, it implies that if a case does not fall into the classification of *maternal death* (by definition) it automatically becomes one of the opposite group.

PUERPERIUM

In the state study, the *puerperium* mentioned above is considered to last 365 days (one year) from the date of delivery for the purpose of collecting "maternal cases." This period of time was adopted originally by the Franklin County Maternal Mortality Committee, after its acceptance by the World Health Organization in 1948.[6] The same terminology is employed in the Vital Statistics Instruction Manual. Furthermore, it is felt by the Committee that this period of time serves a useful purpose in the inclusion of all cases for study, lest a real "maternal death" be omitted erroneously. This feature has proven its point in the case of chorioepithelioma and cervical cancer.

Likewise, the terms *live birth, fetal death, not delivered, gravida* and *para* have been clearly defined by the Committee, and these definitions have proved applicable to this date, without general controversy.[3]

PREVENTION

The program to prevent maternal deaths in Ohio is a large one, with many facets. Indeed, every one of us has a special and important part to play in the whole project, yet no one of us can be responsible directly for a very great part of it. It requires the whole team to complete the plays and reach the goal! In describing a role which you, as members of local Health Departments, might play in this program, I should like to present two phases, i. e., the Indirect and the Direct contributions which you can provide.

INDIRECT

1. **Education.** A well organized program of education, including orientation, is necessary for physicians, interns and residents, nurses, and the lay public. General and specific information concerning the maternal mortality study, its aims and its results (in other localities) must be transmitted tactfully, and correctly to certain key individuals in the community. Conferences can be held with physicians to stimulate their interest in improving the accuracy of diagnoses which they place upon stillbirth and death certificates, as well as charts and hospital records.

Recently, the Joint Accreditation Commission of Hospitals has pursued and achieved an admirable effect upon the rather careless and incomplete execution of hospital records in general, through a program of education and demand. Moreover, it is desirable to point out that the revised Maternity Hospital Regulations 71-93 of the Ohio Sanitary Code (July 16, 1956) offers a modern and workable guide for use in the maternity hospitals of Ohio; if these regulations are followed by medical, nursing, and administrative staffs of various institutions serving maternity patients, many outmoded and ineffectual practices which were tolerated formerly, will be eliminated! Nevertheless, you must be *extremely diplomatic* if you wish to succeed in the acceptable enforcement of these new regulations. Above all, be practical! Remember, teaching is usually planned, but it also may be extemporaneous.

Occasionally, you may have the opportunity to contribute or participate in the sponsorship of certain "refresher courses" offered for the physician who practices obstetrics locally, and who by virtue of his activity is unable to travel to distant points for postgraduate work. You should actively engage in such a project.

In any educational program concerning mortality, it is desirable to include a phase tactfully designed to promote more autopsies upon patients who died in the "maternal case" category. Thorough study of any case is frequently hampered by lack of definite histological study!

2. **Clinics.** In some localities throughout the state where facilities are lacking, it may be feasible to establish some form of a clinic for

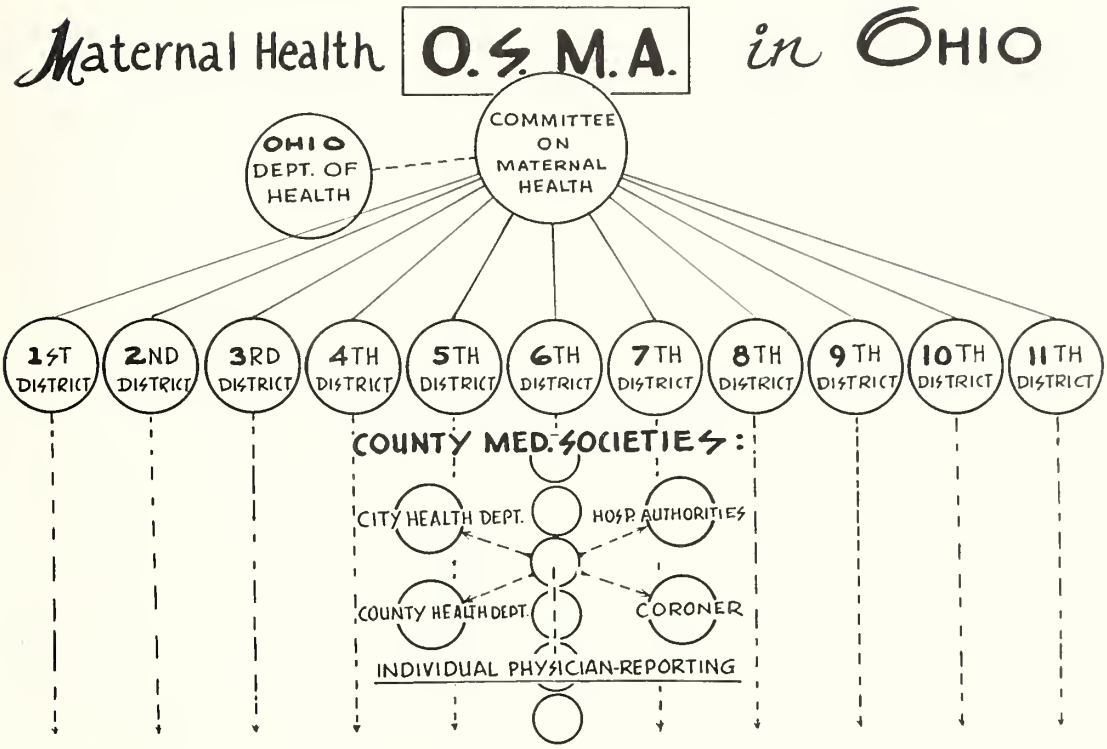


Fig. 1. Graphic chart picturing route taken by each questionnaire mailed by the Committee on Maternal Health to secure data for classification and evaluation in the Ohio Maternal Mortality Study.

prenatal and postnatal care of obstetric patients. Usually this demand appears in an area away from the larger metropolitan centers. The Health Department may well be a cooperative agent in this project, to the vast improvement of local obstetrical practice. In such a clinic, in collaboration with physicians of the community, expectant mothers and their husbands may receive informal, but important education which will eventually safeguard the health of the expectant mother.

DIRECT

1. Under the direct role which you may play in preventing maternal deaths, I would place first, your continued close cooperation with the local Committee on Maternal Health of your County Medical Society. This includes the prompt selection of certain death certificates for females aged 15 to 45 years not only with a cause of death related to pregnancy, but with those indirectly related to pregnancy and described in the foregoing as possible "*maternal deaths*." It has been a custom in Franklin County for the past 8 years, for the Vital Statistics Division to cross-match all death certificates on females of the child-bearing age, with birth certificates for 365 days previous to the date of death. This procedure has revealed a considerable number of "*maternal deaths*" which would have been overlooked otherwise. The practice is heartily recommended to you.

Any other information concerning potential "maternal cases" with deaths due to "other causes," should be transmitted to the chairman of your local Committee on Maternal Health. I might also suggest that you "track down" certain leads which you may receive concerning a possible "maternal case," and apprise your local chairman of the matter; this information is frequently obtained casually from undertakers, nurses, neighbors, and various other lay persons of the community.

2. In this connection, it has been proposed by the Committee on Maternal Health, Ohio State Medical Association, that consideration be given to the addition of a question on the Ohio death certificate form to determine, "If deceased was female, was she pregnant in the past 365 days?" The Ohio Director of Health assures us that the matter will be carefully considered before the next revision of the death certificate form is made. If this item, answered by "yes" or "no" or "unknown" were placed on the form, it would be much easier to cull maternal cases from the vital statistics files with a high degree of accuracy.

3. The legal status of *maternal death* studies poses a frank hazard and often is a moral handicap to individuals of the team operating a maternal mortality study. Ott and Longyear[4] state that the Law Department of the American Medical Association is conducting an extensive study

on this matter, and will report when the study is completed. Can the records be subpoenaed in court? What protection is there for committee members, from legal action, and suit? Recognizing the aims of the mortality study in Minnesota, the legislature enacted a law in 1955 which provides that data from such a study "shall not be admissible as evidence in any action of any kind in any court or before any tribunal, board, agency or person." However, in Ohio, these records are protected by the Ohio Sanitary Code, Regulation 257, entitled "Confidential Nature of Records," effective February 15, 1951. Furthermore, all material and data are collected and presented to the Committee for review evaluation and classification in a completely anonymous manner.

In addition, when cases are published as a part of the educational phase of the program, each case is reported anonymously and at least one year has elapsed after the date of death, in accordance with the provisions of the statute of limitations. These features will be of value to each of you, when you are confronted by questions concerning the liability and legality of the study, from medical members of your community.

4. You may directly assist in the prevention of maternal deaths in your community, by assisting in the establishment of a blood bank, and furnishing certain laboratory facilities for blood typing and determining the Rh factor in red cells of pregnant patients. There will be a greater opportunity for this in smaller communities where adequate laboratory facilities are not readily available.

5. In collaboration with the local Dental Society it may be possible for you to assist in the establishment of a dental clinic for pregnant patients in localities where dentists are overworked with a deluge of private practice.

6. Again, it may be advisable for the nurses of the local Health Department to go into the homes of the community and make prepartum and postpartum calls upon certain selected patients. This worthwhile service to obstetric patients is appreciated by both the patient and the physician, in the larger metropolitan areas, as well as in the smaller cities! And this form of obstetrical care usually pays large dividends in promoting a high plane of maternal health.

There are, undoubtedly, many other small features which may prove worthy of your negotiation at a local level. These, together with the ones enumerated in the foregoing, may enable you to directly prevent maternal deaths in your community. The time allotted for this presentation is entirely too short to present the myriad of possibilities which are potentials in your community. However, if you continue to maintain a friendly liaison with members of your local Committee on Maternal Health, and coordinate "all plays with each member of the team" your concerted efforts will bear fruit in the prevention of maternal deaths.

SUMMARY

1. A brief summary of certain features of the (Ohio) State Maternal Mortality Study, and the Franklin County Maternal Mortality Study are presented. Certain definitions are explained.

2. Methods in which members of local Health Departments may assist in the prevention of maternal deaths in their respective communities are described under indirect and direct categories.

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Effect of Tobacco Chewing On Circulation

Although the annual consumption of chewing tobacco in the United States is 81,000,000 pounds, practically no information is available about its clinical or physiologic effect and specifically its effect on the heart and circulation. To learn more about these effects, Dr. David L. Simon and his associates, University of Cincinnati College of Medicine, studied 24 habitual male chewers (average age 51.1) during and after they chewed both standard commercial (1.53 per cent nicotine) and low nicotine (.31 to .47 per cent) tobacco.

The average amount of tobacco chewed weighed 10 Gm. Observations were made in the basal postabsorptive state following a rest period of at least 45 minutes, and the pulse rate was determined from the electrocardiogram. The blood pressure was taken by a standard mercury sphygmomanometer, and the skin temperatures were measured in a constant temperature room. Ballistocardiograms were recorded with a high frequency table type research instrument. The subjects were supine and unclothed, and chewed for 20 minutes.

In reporting the findings of this test at the meeting of the American College of Angiology, Dr. Simon concluded that the chewing of tobacco in an older group of subjects produces increase in pulse rates, blood pressures, and a drop in skin temperatures, as well as deterioration of the ballistocardiogram, indicating a definite cardiovascular effect.—*Texas State J. Med.*, 52:719, October, 1956.



A CONTINUOUS state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and assisted by official representatives of the various County Medical Societies of the state.

Since work of the committee is educational as well as statistical, summaries of some of the cases studied by the committee, based on anonymous data submitted, will be published in *The Ohio State Medical Journal* from time to time. Each presentation will be brief but informative. It will contain opinions of the committee, based on the data submitted for review. In the series of cases, entitled "Other Causes," the three cases in this fifth report have to do with maternal death due to cerebral hemorrhage.

CASE NO. 26

This patient was a 42 year old, white, Para IV, Cesarean I, who died five hours post cesarean section. Her past history was not remarkable; she had four previous (36 week) pregnancies with vaginal deliveries, one each in 1946, 1948, 1949, and 1950. All babies were living and well; pregnancies were not complicated.

During the last pregnancy she consulted her physician four times; elevation of blood pressure was *first* noted in her thirty-second week as 148/100 without any other symptoms or signs. Treatment prescribed by physician was not recorded; this was her last visit. On April 6 (in her 36th week), early in the morning she was found in a coma in her home, by her husband, and was transferred to the first hospital.

Upon admission, her blood pressure was 178/108, pulse 112, respirations 24, cyanotic and in coma, all deep tendon reflexes absent. Fetal heart sounds were present. Treatment consisted of positive pressure oxygen, resuscitation. Consultation was obtained. As her blood pressure fell intravenous "pressors" were administered, the patient was quickly prepared, and although she was morbid, a classical cesarean section was performed delivering a living 7 pound 10 ounce baby at 10:22 a.m.; it showed signs of anoxia, but lived for 17 hours.

As quickly as possible, the patient was transferred (at 12:45) to the second hospital, where she was placed in the respirator at 2 p.m. A spinal puncture revealed bloody fluid. Diagnosis: massive subarachnoid hemorrhage. Her blood pressure was 40/0, pulse 100, to 120. Her condition continued on a downhill course and she died at 3:45 p.m. the same day. Permission for autopsy was not granted.

Cause of death: Subarachnoid hemorrhage. Pregnancy, uterine, 36 weeks, delivered.

COMMENT

The Committee voted this case a nonpreventable death. It was felt that the emergency measures employed in handling the case were both acceptable and commendable, but for further study into the *direct* causes of these cases of cerebral death in connection with pregnancy, the Committee felt itself hampered by a lack of specific autopsy information.

CASE NO. 67

This patient was a 26 year old, white, full term, gravida III, para II who was seen the day before delivery with normal blood pressure and urinalysis. She died two days postpartum. Report submitted to committee contains no indication of previous prenatal care. Patient had two previous uneventful deliveries. On admission to hospital on July 12, she was in active labor and was noted to have a blood pressure of 160/90 with urinalysis showing red blood cells, white blood cells, casts and 4 plus albumin. She had a normal labor lasting six and a half hours terminated by spontaneous delivery of a 6 pound, 6 ounce baby without anesthesia. One hundred milligrams demerol® during labor was the *only* medication mentioned in the report.

Patient developed headache three hours after delivery and had convulsions one hour later. A second convulsion occurred eight hours after delivery after which she never regained consciousness. Respirations ceased 12 hours after second convulsion but she was kept alive for another 24 hours by artificial respiration and an iron lung. She died July 14. Two consultants concurred in a diagnosis of cerebral hemorrhage but autopsy permission was not obtained. No additional data was included in the report.

Cause of death: (1) Cerebral hemorrhage. (2) Postpartum eclampsia. (3) (Pregnancy, delivered.)

COMMENT

The committee felt that this was probably a nonpreventable maternal death from fulminating

intrapartum, and postpartum eclampsia, complicated by fatal intracranial hemorrhage.

From the available data the lack of prenatal care would offer a possible etiological factor. This would appear to be patient responsibility.

The committee was handicapped in the consideration of this case by the failure to submit information on physical findings, clinical progress, therapeutic measures, and laboratory data in support of the diagnosis. There remains the doubt concerning the promptness of recognition and adequacy of therapy. This serves to emphasize the importance of good records and complete reporting.

CASE NO. 122

This was a 41 year old Negro, para X, weighing 235 pounds who died two days postpartum. She gave a history of nine previous normal deliveries without toxemia. Her last menstrual period was May 5, and when first seen by a doctor on January 6, she was about eight months pregnant. She then had headache, blood pressure 210/130, 4 plus albuminuria and edema. She was next seen on January 10, B. P. 220/130, 4 plus albuminuria and edema. Weight had dropped from 235 to 229 pounds. The patient was admitted to hospital January 11 and treated by bed rest, diet, apresoline,® magnesium sulfate and sedation without improvement.

Membranes were then ruptured artificially and two infusions of intravenous pitocin® were given on January 13 and 14, but did not result in labor. A vaginal examination disclosed a cervix 2 to 3 cm. dilated, long, and firm, with vertex floating. Spinal tap yielded bloody fluid and after consultation a cesarean section was done January 15 under spinal anesthesia and pentothal.® A 4 pound, 4 ounce living infant was obtained. Postpartum course was fair for 36 hours when patient developed fever, delirium, chills, and Cheyne-Stokes respirations. Death occurred two days and six hours after cesarean section. Autopsy permission was granted.

Pathological diagnosis: Intracranial hemorrhage with findings consistent with hypertension and toxemia.

COMMENT

The committee was in agreement that this was a preventable maternal death. Obviously the patient presented herself for prenatal care much too late for the adequate prevention of toxemia, especially in the case of an obese, hypertensive individual.

Criticism was voiced in connection with artificial rupture of membranes in the face of an unfavorable cervix and a floating presenting part. The use of pitocin® intravenous infusion for the induction of labor was questioned in the case of existing hypertension. It was felt that this preparation is never without some pressor effect. In fact it could have been responsible for subsequent intracranial hemorrhage. It was further felt that cesarean section might have been avoided had the membranes not been ruptured, and that further attempts at medical management might have proved to be a more rational therapy.

Immediate hospitalization after the first visit, when the blood pressure was found to be 210/130 with albuminuria and edema certainly was indicated rather than to return the patient to her home to be followed on an outpatient basis. Prompt recognition, proper medical management, and the avoidance of premature surgical interference might have produced a more favorable outcome.

COMMENT OF CONSULTANT

The following comment of a consultant, who is a specialist in neurological surgery, was given at the request of the Committee.

Intracranial bleeding and other vascular accidents occurring during pregnancy and the puerperium have become a problem of considerable importance now that the efficiency of diagnosis and therapy of vascular lesions have improved in these past few years. These three case reports represent a small segment of "vascular accidents" which occur in this period of a woman's life, therefore a brief review of intracranial hemorrhage as it specifically applies to pregnancy and the puerperium is pertinent.

Intracranial hemorrhage* may take place in various sites, i. e., epidural, subdural, subarachnoid (or intraventricular) and intracerebral (subcortical). The common sites for hemorrhage under these circumstances are into the subarachnoid fluid (either into the subarachnoid spaces or intraventricular with subsequent appearance of the blood in the cerebrospinal fluid) and intracerebral (subcortical).

Subarachnoid Hemorrhage. Minor quantities of blood may appear in the C. S. F. (cerebrospinal fluid) from cerebral embolism, thrombosis, sepsis, blood dyscrasias, toxemias (including toxemia of pregnancy), and, of course, minor trauma. Larger quantities of blood in the C.S.F. constitute the common syndrome of "spontaneous subarachnoid hemorrhage" and is most commonly due to the rupture of congenital aneurysms on the vessels comprising the circle of Willis and the adjacent vessels.

It is believed that such aneursyms do not occur any more frequently in pregnancy than they do in the general population. Pregnancy does, however, present greater potential hazards for such an individual, since with pregnancy there may be, (1) increased capillary permeability, (2) changes toward a breakdown in the blood-brain-barrier, (3) the unsolved question of changes in the connective tissue of the body (and blood vessels?), by the effect of "relaxin," (4) and possible changes in capillary endothelium.

Of some importance in this connection is the progressive increase in the plasma volume (40 per cent), total blood volume (30 per cent), and red cell volume (20 per cent), which becomes maximum in the ninth month. These together with the increase in blood fibrinogen, from 0.3 to 0.4 Gm. per 100 ml., are of undoubted importance in

*We are not herein concerned with the rare, but important, other intracranial vascular and hemorrhage problems that occur during pregnancy such as, (1) intracerebral, cerebellar and brain stem angiomas with thrombosis or hemorrhage, (2) "puerperal hemiplegia" (cerebrovascular thrombosis), and (3) intraventricular hemorrhage from malignant gliomas.

some of the intravascular problems that appear at term and in the puerperium. In both the pregnant and nonpregnant individuals, factors which increase intravascular pressure are predisposing to rupture of an intracranial aneurysm. The changes in intravascular pressure during labor are no exception and are cause for breakdown in the wall of an aneurysm, which may lead to immediate hemorrhage or may bring about hemorrhage later on, that is, possibly sooner than it would otherwise have ruptured.

The symptoms of acute intracranial subarachnoid hemorrhage are no different in the pregnancy or in the puerperium. These may vary from a mild headache, frequently behind one eye associated with slight stiffness of the neck to a sudden violent head pain followed in seconds to minutes by coma and subsequent death. All too frequently intracranial localizing signs are not present. The diagnosis of subarachnoid hemorrhage, although it may be suspected, is to be made by lumbar puncture.

Treatment presents a problem and too few immediately nonfatal cases in pregnancy have appeared to lay down specific rules.

With increasing success in the surgical treatment of intracranial aneurysms, it is becoming evident that certain of these aneurysms should be treated surgically, whether or not the patient is pregnant, because of the high mortality of the lesion itself and the increasingly lower mortality from the surgical procedure.

In general, however, if the hemorrhage occurs during or close to labor, then *cesarean section* is the method of choice of delivery. If the hemorrhage occurs in the first, second and early in the third trimester of pregnancy then therapy will depend on the findings of cerebral angiography, at which time the many factors pertinent to each particular situation must be weighed before a therapeutic course is instituted.

Intracerebral hemorrhage occurring as suggested on Case 67 and Case 122 presented in the foregoing, are not unlike those from other patients who have essential hypertension except for those conditions during pregnancy which affect capillary and arteriolar permeability, as previously mentioned. Obviously severe cerebral hemorrhage into cerebral tissue will clinically appear as a subarachnoid hemorrhage (blood in C. S. F.), but is frequently accompanied by obvious focal neurologic signs (hemiplegia), unless immediately fatal. Such hemorrhages are all too frequently severely devastating to cerebral tissue even when not fatal.

Therapy must be directed at prevention of toxemia of pregnancy or further elevation of arterial pressure when it is consequent to essential arterial hypertension. In addition to the usual therapeutic routine, the obstetrician must be ready to lower the arterial pressure with one of the newer sympatholytic drugs, (bistrium®—hexamethonium bromide, ansolysen,® inversine,® et cetera).

In this group, rarely is it necessary to resort to cesarean section for delivery unless a fatal hemorrhage has occurred. Proper medical management should prevent most such instances. Unless severe hemorrhage causes a localized intracerebral blood clot, neurosurgical intervention is indicated and may be quite successful.

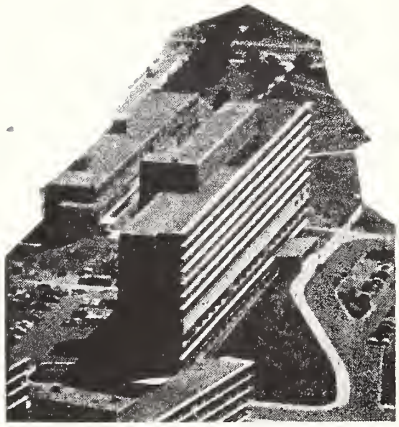
Other forms of intracranial bleeding are much less common but should be mentioned. Subdural hematoma, acute or chronic, occur during labor consequent to straining or minor head injuries and also during the puerperium. In the latter instance, it may be associated with anticoagulant therapy for thrombophlebitis. Signs of increased intracranial pressure (headache, nausea, vomiting, bradycardia, arterial hypertension, papilledema, etc.), with or without localizing signs (dilatation of one pupil, unilateral weakness, unequal tendon reflexes, focal convulsions, etc.), give cause for immediate neurologic evaluation and therapy, no matter when this occurs, the course of pregnancy or the puerperium. The same applies to the very rare case of epidural hemorrhage.

Early recognition of these complications of pregnancy and the puerperium and a knowledge of their therapy can lead to a further reduction in the maternal mortality and morbidity.

The Pharmacological Action Of Topical Medication

FUNGICIDES: Our success with the antifungal drugs has been far less startling [than with antiinfectives, which drugs act by a direct bacteriostatic bactericidal effect on the microorganism]. We still have no wholly satisfactory fungicide. At present all of them which are really efficient fungus inhibitors *in tissue* are also destructive to the tissue, especially if it is raw and inflamed. In the opinion of most dermatologists the fatty acids, such as undecylenic acid, and salicylanilide are not very effective, and others are toxic and allergenic.

As a matter of fact, fame and fortune may have brushed very close to me a few years ago when there appeared on a petri dish culture of Trichophyton rubrum a tiny black shiny colony which inhibited the growth of this very resistant fungus species for at least 2 cm. around it. We postulated a soluble, colorless bacterial product with strong anti-fungal properties and tried feverishly to isolate it. All to no avail however, for we lost it and have never seen it since. That's how near I came to standing in history beside Alexander Fleming. Seriously, though, it is amazing how many drugs have been ineffective on the skin after being violently fungicidal in the test tube.—Robert G. Carney, M. D., Iowa City, Iowa: *South Dakota J. Med. & Pharm.*, 9:381, October, 1956.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Ralph J. Johansmann, M. D., President

Presented by P. T. Knies, M. D., and Emmerich von Haam, M. D. Edited by Dr. von Haam

PRESENTATION OF CASE

A FORTY-EIGHT YEAR OLD colored male was admitted to University Hospital complaining of shortness of breath and swelling of the legs and abdomen for one month prior to admission. He was first seen here one year ago, when he was admitted with a history of blood in his urine, shortness of breath and ankle edema of approximately five years' duration. Several years ago he had been a patient in Benjamin Franklin Tuberculosis Hospital but no active disease was found. Previous x-ray examination of his chest revealed chronic pulmonary emphysema with large bullous blebs in both apices and a cor pulmonale.

Arterial blood studies done two years ago showed an oxygen saturation of 79.7 per cent and a *p*H of 7.29. At that time he was digitalized and put on a cardiac regimen, to which he responded fairly well. The histoplasmin and PPD (purified protein derivative [tuberculin]) tests were negative. He was seen again two years later, at which time the findings were similar. He was continued on digitalis, low-salt diet and mercuhydrin.®

Since that time he had received no medication and noted increasing shortness of breath and swelling of the legs. He denied any cough or urinary symptoms. There was no history of chest pain. He had lost 20 pounds in the past one and a half months. The patient had worked some time before in a coal mine as a stone cutter, where he had fainted on one occasion. He had been a heavy drinker until about two years before his final hospitalization.

PHYSICAL EXAMINATION

The patient's blood pressure was 110/80, his pulse 80, respirations 32 and temperature 96°F. He was a well developed Negro appearing the stated age, in moderate respiratory distress, showing 4 plus pitting edema of the legs, hips, sacrum, upper extremities and lower back. The neck veins were markedly distended. The sclerae were muddy; there was arcus senilis. The fundi showed arteriolar narrowing with minimal nicking. The neck was supple, the thyroid not palpable.

There was a slight increase in the anteroposterior diameter of the chest. Percussion revealed hyper-resonance except for dullness over both bases posteriorly. Moist rales were also heard over the bases posteriorly. The heart extended to the left anterior axillary line; the heart sounds were faint. There was normal sinus rhythm and no murmurs could be heard.

The abdomen was distended and shifting dullness and a fluid wave were present. The liver was felt 3 to 4 fingerbreaths below the right costal margin. The spleen and kidneys were not palpable. There was moderate scrotal edema. Rectal examination revealed a very firm, slightly enlarged prostate. The neurological examination gave normal findings.

LABORATORY DATA

The urine had a specific gravity of 1.011, showed a trace of sugar and had finely granular casts and 10 to 20 red blood cells per high power field in the sediment. The white blood count was 6,650 with a normal differential count; the red blood count was 7.05 million, the hemoglobin 16.5 Gm. The CO_2 combining power of the plasma was 37 vol., the blood urea nitrogen 35.5 mg., the blood sugar 75 mg., plasma prothrombin 25.5 per cent. The oxygen capacity at rest was 22.76 vol.; the oxygen saturation was 43.1 per cent.

Other blood chemistries were as follows: inorganic phosphorus 5.4 mg., alkaline phosphatase 5.6 units, acid phosphatase 0.3 units; total protein 7 Gm., albumin 3.5, globulin 3.5; sodium 151 mEq., potassium 5.4 mEq., chloride 105 mEq.;

icterus index 15; van den Bergh 1.1 mg. direct, 1.8 mg. indirect; thymol 30; calcium 12 mg.; cephalin flocculation 1 plus. Examination of the spinal fluid gave a chloride content of 736 mg. and a sugar of 73 mg.; the fluid was negative for globulin and was sterile on culture; microscopic examination showed 22 red blood cells per cu. mm.

X-RAY EXAMINATION

Due to his short stay in the hospital no pictures were taken. Previous chest films showed an enlarged heart silhouette suggestive of principal enlargement of the right ventricle. The lungs showed diffuse pulmonary fibrosis with bullous emphysema of the left upper lobe. A possible bronchiectasis was considered. His pyelogram showed poor visualization of the calyces of the left kidney, without evidence of a clear-cut filling defect.

The electrocardiogram showed a right axis deviation and an increased peaking of the T-waves.

HOSPITAL COURSE

Shortly after admission the venous pressure was 340 mm. of water, the right atrial pressure after catheterization was 340 mm. of water. Over the course of 30 minutes 700 cc. of blood was withdrawn by venesection. The procedure was tolerated fairly well, but about 10 minutes later the patient became restless and increasingly short of breath. He was returned to his room immediately and his blood pressure was found to be 100/70, the pulse 86.

The patient became almost moribund and only some left facial response could be elicited. He did not respond to painful stimuli in the left extremities. He continued to respond poorly that day and developed a left hemiplegia. The impression was that the patient had a cerebral thrombosis in the left internal capsule. He was started on tube feeding and began to have respiratory distress the following day. He remained comatose and was pronounced dead early the following morning.

CLINICAL DISCUSSION

DR. P. T. KNIES: The case history to be considered today is that of a 48 year old colored male who was admitted with clinical evidence of congestive heart failure. For five years he had presented a history of increasing shortness of breath, increasing edema which by the time of hospitalization was described as a Grade IV, and a progressing abdominal enlargement. It had also been noted on chest x-ray that the transverse diameter of the heart was increased some 40 per cent and the electrocardiogram showed a cor pulmonale. His neck veins were markedly distended and the venous pressure as determined in the right auricle was 340 mm. of water, which represents a tremendous increase over the normal maximum of approximately 120. We then have the picture of chronic pulmonary emphysema complicated by right heart failure. We feel that the patient has a cor pulmonale with eccentric hypertrophy of the right ventricle and dilatation of the right auricle.

FIBROSIS

The lungs showed the picture of chronic pulmonary fibrosis, and he had twice been admitted to a sanitarium with a diagnosis of suspected pulmonary tuberculosis, which was not sustained. His negative PPD and histoplasmin skin tests, and the story that he had been working as a stone cutter in a coal mine suggest pneumoconiosis. We don't know the nature of the stone with which he worked, but it does not have to be a silicon-containing stone in order to cause pneumoconiosis.

His sputa had been repeatedly negative for tubercle bacilli at the sanitarium. The apical breath sounds were listed as tubular, which means large air-containing spaces contiguous with the air in the bronchi, whether they are cavities or emphysematous bullae. He had a marked bullous emphysema at the left apex, and once it was thought that a similar bullous emphysema at the right apex represented a tuberculous cavity, which however did not prove correct. For this reason we are hesitant to make a diagnosis of pulmonary tuberculosis but prefer to think of pulmonary fibrosis with bullous emphysema.

A consequence of that bullous emphysema was a relative respiratory inadequacy which is expressed by the elevated plasma carbon dioxide content and the decreased oxygen saturation in the peripheral blood. Another supporting evidence is the red blood cell count of over 7 million, suggesting a secondary polycythemia. His respiratory excursion was diminished and his vital capacity was only 25 per cent of the predicted value.

LIVER DYSFUNCTION

He apparently also had some dysfunction of the liver, and the question arises what factors may have been responsible for his hepatic pathology. Considering what we have already said about the tremendously increased venous pressure, it would be possible that this liver enlargement might be entirely due to circulatory failure. Nevertheless, the rapid fall in his prothrombin from 46 to 25 per cent in a few months time, and the results of the other liver tests would suggest damage to the liver parenchyma. Because of the history of heavy alcoholism we may think of an early Laënnec's cirrhosis complicated by chronic congestion of the liver and the chronic anoxemia.

There is one symptom complex that I cannot be sure how to explain and that is the history of hematuria. It was noted also at his previous admission and cannot be due to his hypoprothrombinemia. The urine was repeatedly examined and found negative for acid-fast bacilli. He also

had a 24-hour urine concentrate examined by the Papanicolaou technique for malignant cells, and that was negative. Two intravenous pyelograms were inconclusive and there was only minimal evidence of renal failure, with essentially normal serum electrolytes.

Considering the age and race of the patient, one must certainly consider tuberculosis. However, in this case I would have expected him to have a positive tuberculin test, and if he had a bleeding tuberculous lesion one would expect that one or more specimens would have yielded tubercle bacilli. Thus I would say that the evidence against tuberculosis is stronger than the evidence against a malignant tumor. One 24-hour urine concentrate examined by the Papanicolaou technique cannot be considered reliable evidence. One can of course have renal bleeding of slight degree on the basis of passive congestion. That is not a common observation, but if the congestion is combined with hypoprothrombinemia hematuria may occur.

HOSPITAL COURSE

His hospital course was very interesting. Because of the high venous pressure and the obvious right heart failure a phlebotomy was done, during which 700 cc. of blood were removed in a few minutes' time. Ten minutes later the patient developed increasing shortness of breath, restlessness, fall in blood pressure, paralysis and aphasia. The type of paralysis suggested a left central nervous system lesion which could have occurred either on the basis of anoxemia *per se*, or on the basis of vascular thrombosis caused by the drop in blood pressure following the phlebotomy.

It was interesting that his plantar reflexes remained plantar and the Hoffmann was negative. Because of that I am not going to discard the possibility that his central nervous system may show no outstanding arterial pathology but that the paralysis may have been due to the fact that the oxygen supply to the brain had fallen below the critical level of neuron requirements as a result of his emphysema and his heart failure and the vascular collapse following the phlebotomy.

It is rather remarkable what can happen to one's arterial blood pressure when the pressure of the venous side is suddenly decreased by 700 cc. The disturbance of the homeostasis, whether it be by phlebotomy, by the withdrawal of a considerable amount of fluid from a chest cavity, or by withdrawal of large amounts of ascites, or even by the release of large amounts of flatus, can many times provide a vascular shock which the individual cannot survive.

In summary then I would state that the patient suffered from pulmonary fibrosis probably on the basis of an acquired pneumoconiosis or an old healed tuberculosis with emphysema and a cor pulmonale. The latter was primarily responsible for his congestive heart failure. The liver probably will show Laënnec's cirrhosis with superimposed chronic passive congestion. The kidney lesions as suggested by his hematuria and the inconclusive pyelogram must remain obscure. I also think that the patient suffered a recent encephalomalacia involving the left hemisphere or the left internal capsule.

GENERAL CLINICAL DISCUSSION

MEDICAL STUDENT: What was the cause of his pulmonary fibrosis?

DR. KNIES: Since the fibrosis extends all the way to the periphery, where we find the emphysematous bullae, I believe that it occurred before the bullae formed and that it represents an old lesion, probably pneumoconiosis or an old healed tuberculosis.

DR. MANCHESTER: Could he have suffered from bronchiectasis?

DR. KNIES: I do not think that either the clinical picture nor the chest film make such a diagnosis probable.

CLINICAL DIAGNOSIS

1. Cor pulmonale with congestive failure.
2. Chronic pneumoconiosis with chronic emphysema.
3. Laënnec's cirrhosis with congestive hepatomegaly.
4. Recent vascular thrombosis with encephalomalacia.

PATHOLOGIC DIAGNOSIS

1. Sickle-cell trait in acute crisis with formation of numerous intravascular clots.
2. Bullous emphysema of lungs.
3. Chronic pneumoconiosis.
4. Chronic bronchitis with bronchial asthma.
5. Cor pulmonale with congestive failure.
6. Recent infarcts of spleen and kidney.
7. Recent encephalomalacia.

PATHOLOGICAL DISCUSSION

DR. VON HAAM: Dr. Knies's analysis was very thorough and while he has pointed out very correctly the pathological lesion of our patient he did not discover what I consider was the common etiology behind most of his complex lesions. I cannot blame him for this, as I don't believe it could have been done on the basis of the clinical findings and laboratory tests performed. However, I shall show you the slides and I believe that you can make the diagnosis yourselves.

Many of Dr. Knies's predictions were absolutely confirmed at autopsy. The patient had severe edema, some ascites and some hydrothorax. The patient's heart was enlarged and the right ventricle measured 2.5 cm. in thickness, which means a tremendous hypertrophy of the right heart muscle. There was a mural thrombus in the dilated right atrium, as we sometimes find in a

cor pulmonale, where there is much stagnation and back pressure.

The lungs showed large emphysematous bullae and they were heavily pigmented and of rubbery consistency. They confirmed Dr. Knies's diagnosis of pneumoconiosis with fibrosis and bullous emphysema. There was no bronchiectasis and there was no evidence of active tuberculosis. The mediastinum contained a few calcified lymph nodes.

The liver was decreased in size but did not show any cirrhosis, only the nutmeg pattern of severe chronic congestion. The gastrointestinal tract was moderately congested but otherwise normal. The spleen showed two small infarcts, and the kidneys also contained small old and more recent infarcts. That may well have accounted for the hematuria which puzzled the clinician. The brain also showed the lesion which Dr. Knies expected us to find. The left internal capsule contained a recent hemorrhage extending about 6 cm. in diameter. Thus the gross findings of the autopsy seem to confirm perfectly the clinical diagnosis.

MICROSCOPIC EXAMINATION

Sections through the heart showed numerous scars from small myocardial infarcts without evidence of coronary sclerosis or of myocarditis. The heart muscle seemed to be riddled with these small scars, and this explains the rapidly progressive heart failure. Sections through the lung confirm the diagnosis of pneumoconiosis with diffuse fibrosis, dust granulomas, chronic bronchitis and emphysema. There was also a marked sclerosis of the pulmonary arteries, supporting evidence of pulmonary hypertension. Sections through the spleen and kidney confirmed the diagnosis of recent infarcts, and the microscopic examination of the brain showed numerous small vessels plugged by recent thrombi with large and small areas of encephalomalacia and secondary hemorrhage.

SICKLE CELLS

The red blood cells in all blood vessels showed pronounced sickling and it is this observation which provides us with the underlying cause of many of the lesions observed in this patient: sickle-cell trait or heterozygous sickle-cell disease. This condition is present in above 8 per cent of the Negroes in the United States. The majority of patients thus affected have no anemia and no sign of abnormal blood cell destruction. In conditions characterized by severe hypoxia such as in emphysema or pulmonary fibrosis, a so-called "sickle-cell crisis" may be evoked characterized by the formation of numerous sickle-cell clots in the blood vessels with the formation of infarcts and focal necrosis of all organs. Our patient showed evidence of such vascular occlusion in the heart, kidney, spleen and brain.

The trigger mechanism for his "crisis," and he probably had had many of them during his last several years, was the hypoxia caused by his pulmonary disease. This crisis was not of the hemolytic type as found in typical sickle-cell anemia but characterized by obliterative vascular phenomena. Sometimes such vascular crises can even lead to unexpected sudden death, although this was not the case here, since the patient's cerebral symptoms were well recognized. The condition, when suspected, can be diagnosed by an appropriate laboratory test which will demonstrate the sickling of red blood cells after artificial deoxygenation. This test was not done on this patient.

GENERAL DISCUSSION

DR. KNIES: With the exception of the realization that an individual of this race might have a sickle-cell tendency, what is there in your opinion about this case that should have led us to this diagnosis?

DR. VON HAAM: Nothing, absolutely nothing unless you became suspicious of the multiple thrombotic lesions, unless you speculated that the kidney lesions could be an infarct and the weak heart could be based on myocardial infarcts, and the brain lesion could be a result of vascular thrombosis. Of course you could not even suspect the infarcts of the spleen since he did not have any pain in this region. In certain places, as in Memphis for example, the examination of sickle-cell preparations is routine as much as the Wassermann test, just in order to uncover any obscure sickle-cell traits.

DR. KNIES: Why didn't his left kidney function normally on the intravenous pyelogram?

DR. VON HAAM: The ureter may have been obstructed temporarily by a blood clot.

MEDICAL STUDENT: Can you pick up a sickle-cell trait with the sodium bisulfite method?

DR. KNIES: You can if you look for it.

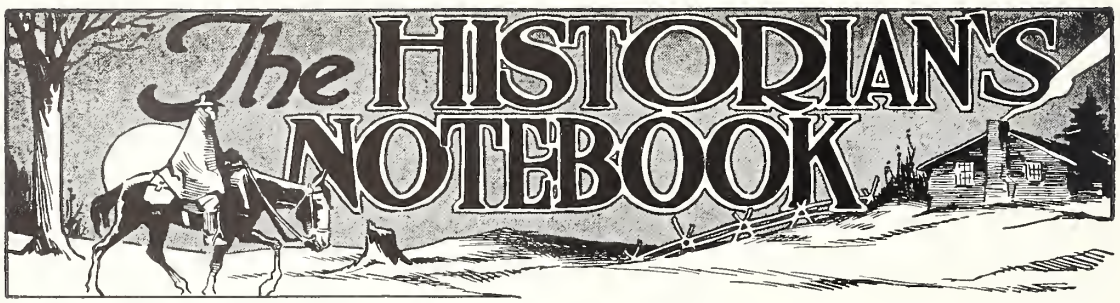
MEDICAL STUDENT: There was a report in the *Annals of Medicine* about two months ago of Wernicke-like symptoms in colored troops who were being transported at high altitudes and it was felt that in high altitudes colored soldiers may suffer an episode of hypoxia which accounted for cerebral thrombosis and infarction. This would represent a similar situation as this case here where the hypoxia resulted in small infarcts throughout the body.

DR. VON HAAM: It is the hypoxia which brings about the vascular sickle-cell crisis.

DR. SCHIEVE: What gave him the cerebral hemorrhage?

DR. VON HAAM: Small thrombi which produced an area of encephalomalacia with secondary hemorrhage.

DR. KNIES: I think I have learned one thing from this case, or learned it for the umteenth time, and that is the ubiquity of sickle-cell disease and the many lesions it can produce.



The Medical Men in George Washington's Life

VICTOR R. TURNER, M. D.

PART I

FROM the time when George Washington as a boy delighted to buy brown and white sugar candy from Old Doctor Wm. Lynn's Apothecary Shop until that bleak Saturday night on December 14, 1799, when he looked up into the eyes of his old friend, Dr. James Craik and said, "Doctor, I die hard, but I am not afraid to go," his life was closely associated with the members of the medical profession.

In his early childhood, there was Dr. Charles Green, a great friend of Augustine Washington, George's father; and there was Dr. John Mitchell, the best-trained physician in Washington's boyhood; also there was Dr. John Tennant in Fredericksburg who was regarded as a genius by some as he tried to prove the singular virtues of snakeroot to the world; and there was Dr. Wm. Hillary who treated Washington's half brother, Lawrence, for what undoubtedly was tuberculosis.

SMALLPOX; 1751

On the morning of November 14, 1751, when George was 19 years old, he awoke with a terrific chill and a high fever. Before evening, he was seized with a violent headache and with pains in his back and loins. On November 20th, red spots were discernible on his forehead and among the roots of his hair. Dr. Lanahan was called in and made a diagnosis of smallpox. On the 28th, pustules which had developed, dried up. The suppurative fever diminished and disappeared.

A few months later, in March 1752, George was stricken with pleurisy which, as he subsequently wrote, rendered him very low and left him much weakened; Dr. Hillary was probably his physician at this time.

Of all the physicians associated with George Washington, professionally or otherwise, Dr. James Craik was the dearest to his heart. Dr. Craik was born in Scotland in 1736 and received his medical education at the University of Edinburgh. He joined the British army as a surgeon and came to America with the army in 1750. He was a member of Braddock's ill-fated expedition at Fort Duquesne and attended General Braddock when he died from the effects of wounds which he had received.

Dr. Craik met Washington on his first expedition and the two became fast friends. In 1770, they made a horseback and canoe trip together to the Ohio river, locating lands. After the French and Indian War, Dr. Craik practiced medicine in Virginia until in the spring of 1777. Washington wrote the following letter to him, tending him the position of Medical Director of the Medical Department of the Army:

> "You know how far you may be benefitted or injured by such an appointment and whether it is advisable or practicable for you to quit your family and practice at this time. I request, as a friend, that my proposing this matter to you may have no influence on your acceptance. I have no other end in view than to serve you."

Dr. Craik accepted the appointment and in this capacity organized the hospital services of the French army under Rochambeau. After the reorganization of the Medical Department in 1781, Dr. Craik was elected Chief Physician and Sur-

Submitted August 21, 1956.

The Author

● Dr. Turner, Newark, Ohio, now retired, was formerly roentgenologist and radiologist at the Newark City Hospital.

geon of the army, the next to the highest position in the army. Dr. John Cochran, of New Jersey, occupied the highest position as Director General at that time. Dr. Craik served in this capacity until December, 1783, when he resigned from the army and was induced by Washington to practice in Alexandria, Virginia, near Mt. Vernon.

Perhaps the greatest service Dr. Craik did for Washington and for his adopted country was at Valley Forge. Washington's star had reached a new low. He had lost the battle of Long Island and had given up New Jersey to the enemy. He was defeated at the Battle of Brandywine when Lafayette was wounded and Washington had sent Dr. Benjamin Rush, Dr. Latimer, Dr. Way, and Dr. Coates under a flag of truce to look after him and the other wounded. He had been repulsed at the battle of Germantown and had to retreat.

Washington decided on Valley Forge for winter quarters, and on December 1, 1777, the army marched into Valley Forge. Deborah Logan, who had watched the British march into Philadelphia, said, "The contrast between them and our poor ragged, barefoot boys caused a feeling of despair." As Dr. Albigene Waldo of Col. Prentice's Connecticut regiment says of Valley Forge, "I am sick, discontented, out of humor, poor food, hard lodgings, cold weather, fatigue, nasty clothes, nasty cookery, vomit, smoked out of my sense, the Devil is in it—I can't endure it—there comes a bowl of soup full of burnt leaves and dirt."

CONWAY CABAL

It was in this setting that Thomas Conway, who had served in the French army 30 years and had been appointed Brigadier General in the Continental Army and was Inspector General of the Army, stepped into the picture. He proved to be worthless and worse, engaged in a plot to supplant Washington and place General Gates at the head of the Continental Army. It was Dr. Craik who got wind of the plot and warned Washington in time to suppress the so-called Conway Cabal; otherwise the course of our history might have been changed.

Two doctors from New Jersey stood high in Washington's esteem. One was Dr. John Cochran of Brunswick, New Jersey; the other was Dr. Wm. Burnet of Newark, New Jersey. Dr. Cochran was born in Pennsylvania. He studied medicine under Dr. Thompson of Lancaster, Pennsylvania, and then began his practice at Brunswick, New Jersey. In 1776, he was Assistant Director of the Flying Corps; in 1777, he was Surgeon General of the Medical Department; in 1780, he was Chief Physician and Surgeon of the Army, and on January 31, 1781, he became Medical Director of the Continental Army, the highest position in the Medical Department of the army. The last appointment was directly due to General Washington. He was fortunate in having Dr. James Craik as his second in rank. They both were Scots, both highly esteemed and recommended by Washington and both were above suspicion of profiting or self seeking.

On March 26, 1781, Dr. Cochran wrote his friend, Dr. Craik, "I am just returned from an eighteen-day trip up the North River to attend Mrs. Washington. We had an agreeable jaunt, excepting the business of the roads, but we met with so much hospitality wherever we went that compensation was made for the difficulty in traveling."

Dr. Cochran was the last of the four physicians who headed the Medical Department of the Continental Army. The first was Dr. Benjamin Church of Boston, Massachusetts. Dr. Church was a graduate of Harvard and received his medical education in Europe. He was an intense patriot and a very successful physician and surgeon as well as being socially prominent. He was selected to receive General Washington when he arrived in Cambridge to assume command of the Continental Army. Dr. Church's administration as Director General during the few months he held it was not marked by harmonious or successful management. There were frequent complaints and misunderstandings with the regimental surgeons.

DR. CHURCH—A TRAITOR

In September, 1775, Dr. Church was detected in sending a letter to Major Cain of the British army in Boston. The letter was entrusted to a young woman, but it was taken from her by a Mr. Wormwood of Newport and was sent to General Washington. The letter was in cipher but was deciphered by Reverend Samuel West and found to be made up mostly of a description of the American forces, but contained no disclosures of great importance. On October 3, 1775, a council of war was called with General Washington presiding. Dr. Church's plea was a desire to draw information from the enemy. He was found to be guilty of criminal correspondence with the enemy and the case was referred to the Continental Congress.

On November 6, 1775, the Congress voted that Dr. Church be dismissed from the army and he was imprisoned at Norwich, Connecticut. On account of ill health, he was allowed to return to Boston under bond, and in 1776 permission was given him to visit the West Indies. The vessel he sailed on was never heard from again, thus ending miserably a career which promised so much.

On October 1, 1775, Congress elected Dr. John Morgan, of Philadelphia, Director General of the Army. Dr. Morgan was a graduate of the College of Philadelphia and received his medical degree from the University of Edinburgh. He also studied under the great Dr. John Hunter in London. In 1765, he and Dr. Wm. Shippen founded the first medical school in America in Philadelphia. Dr. Morgan was professor of medicine and Dr. Shippen was professor of sur-

gery at the medical school. Dr. Morgan was a close friend of Benjamin Franklin and was held in the highest esteem by General Washington.

At the time Dr. Morgan was Director General, the Continental Army suffered a serious defeat in the battle of Long Island. It was almost impossible to get food, clothes, medical and surgical supplies for the sick and wounded. Dr. Morgan, however, gathered what supplies he could while riding horseback from Boston to as far south as Baltimore. He instructed incapable surgeons, dealt with insubordinate officers, and did surgery with his own hands.

Of course, many complaints came back to Congress about the Medical Department and Dr. Wm. Shippen did everything he could to have Dr. Morgan replaced by himself, and worked on the members of Congress while Dr. Morgan was at the front. On January 9, 1777, without consulting General Washington, Dr. Morgan was dismissed from the army by the Congress. A later committee found Dr. Morgan's character and ability above reproach and he was completely exonerated. However, his reputation was ruined and he died a broken-hearted man in 1789.

Dr. Wm. Shippen, who replaced Dr. Morgan, was a graduate of Princeton and the University of Edinburgh Medical School. He studied under Dr. John Hunter and Sir John Pringle in England and later studied in Paris. As before mentioned, he and Dr. Morgan founded the first medical school in America and he was professor of surgery. The medical school was suspended in 1775 because of the war and Dr. Shippen entered the army as a surgeon in the Flying Corps. Later, through a political maneuver, he was made director of the hospitals west of the Hudson and in 1777 he became Director General of the Army Medical Department. He held this position until 1781.

DR. SHIPPEN; BENEDICT ARNOLD

Dr. Shippen's family was distinguished and he was a cousin of the beautiful Betsy Shippen who later was Mrs. Benedict Arnold. His wife was the daughter of General Lee of Virginia. Loud complaints were registered against Dr. Shippen's administration of the Medical Department of the Army. Dr. Shippen settled himself at Bethlehem, Pennsylvania, and, according to sworn statements of medical men, he scarcely ever visited the hospitals and spent his evening in social entertainment and gambling.

On January 30, 1778, Dr. Benjamin Rush addressed a long letter to General Washington. In the letter, he gave evidence of misappropriation of supplies by Dr. Shippen for his own benefit. He disclosed the falsity of Dr. Shippen's report regarding the sick and wounded. General Washington sent the letter to Congress.

Dr. Morgan, supported by Dr. Philip Turner, Surgeon General of the Eastern Department at the time, Dr. John Warren, and Dr. James Tilton, brought charges against Dr. Shippen. On July 28, 1778, Dr. Shippen addressed Congress professing to be anxious to be tried and asked for a copy of the charges.

On October 25, 1779, Dr. Morgan again wrote Samuel Huntington, President of the Congress, regarding the charges against Dr. Shippen. He said that in a conference with General Washington, that Washington said he would order a court martial at the end of the campaign. The court martial was ordered and on March 15, 1780, met at Morristown, New Jersey. The court acquitted Dr. Shippen for the reason that the charges were not clearly proved.

On January 3, 1781, Dr. Shippen resigned from the army and became a professor of surgery when the Philadelphia Medical College became a part of the University of Pennsylvania. Later he founded the College of Physicians and Surgeons and was its president from 1805 to 1808. He died July 19, 1808.

THE BATTLE OF MONMOUTH

On the extremely hot night of June 26, 1778, just before the battle of Monmouth, Dr. James Griffith of the Third Virginia Regiment rapped loudly on the door of General Washington's headquarters and demanded an interview with the general. He was admitted into the presence of General Washington and informed the General that General Charles Lee was to prove a traitor on the next day. Evidently, the General did not believe the information to be entirely reliable, or else failed to act upon it. At any rate, on the day of the battle, when many soldiers on each side were dying from the terrific heat as well as from battle wounds, Dr. Thomas Henderson of Monmouth, brought the news to Washington of General Lee's treacherous retreat, and it was then that General Washington rode up and rebuked Lee and relieved him of his command on the field of battle.

(To Be Concluded in February Issue)

Rare Historical Collection

Dr. Victor R. Turner, of Newark, author of the foregoing article, has a collection of letters and autographs of great men and women of history which has taken him many years to assemble. In the collection are some 50 medical items with a large number of autographs, including those of Benjamin Rush and Edward Jenner.

History of Medical Society Of State of New York

The history of the Medical Society of the State of New York is now in the process of compilation for publication in the Sesquicentennial issue of the *Journal*, February 1, 1957. This is a task of some magnitude requiring the collection from various sources of voluminous material which must then be condensed to its final form.—*New York State J. Med.*, p. 3643, December 1, 1956.

Report of AMA Session . . .

House of Delegates Takes Action on Medical Ethics; Veterans Medical Care; Approves Ohio-Sponsored Policy on Administering Radiation

MEDICAL ETHICS, veterans' medical care, radioactive isotopes, continuance of the AMA interim session, hospitalization for patients with alcoholism and a report of the Committee on Medical Practices were among the wide variety of subjects acted upon by the House of Delegates at the American Medical Association's Tenth Clinical Meeting held November 27 - 30 in Seattle.

The Ohio State Medical Association was represented by its official delegates who are the following: Dr. C. C. Sherburne, Columbus; Dr. Richard L. Meiling, Columbus; Dr. Carl A. Lincke, Carrollton; Dr. George A. Woodhouse, Pleasant Hill; Dr. Charles L. Hudson, Cleveland; Dr. Paul A. Davis, Akron; Dr. Carll S. Mundy, Toledo; Dr. L. Howard Schriver, Cincinnati. Mr. Charles S. Nelson, Columbus, Executive Secretary of the Association, accompanied the delegation. Dr. Charles L. Leedham, of Cleveland, represented the AMA Section on Military Medicine in the House of Delegates.

MEDICAL ETHICS

Subject of greatest interest at Seattle was the proposed, ten-section revision of the Principles of Medical Ethics originally submitted at the June, 1956, Annual Meeting in Chicago, where final action was deferred until the Seattle session. The proposed short version of the Principles was resubmitted in Seattle, with some changes based on suggestions received since last June by the Council on Constitution and By-Laws. The House of Delegates, however, decided to refer the matter back to the Council on Constitution and By-Laws for further study and consideration. The reference committee report adopted by the House included the following statements:

"Careful consideration was given to the Preamble and the ten sections of the proposed Principles. The Preamble and seven of the ten sections appear to be acceptable in their present form.

"Sections 6 and 7 were not acceptable as presented either to the group which appeared at the hearing or to your reference committee.

"Out of the general discussion the reference committee received the crystallized opinion that at least four areas needed more specific attention in Sections 6 and 7. These are:

"(1) Division of fees;

"(2) The dispensing of drugs and appliances;

"(3) The corporate practice of medicine;

"(4) Greater emphasis concerning the relationship between physicians and patients.

"In addition, the reference committee felt that the wording in Section 10 could be improved if amended to read as follows:

> " 'The responsibilities of the physician extend not only to the individual but also to society and deserve his interest and participation in activities which have as their objective the improvement of the health and welfare of the individual and the community.'

"In view of the above your reference committee believes that the proposed Principles of Medical Ethics should be referred back to the Council on Constitution and By-Laws for further study and consideration of the above stated principles.

"In the short space of time at our disposal and in view of the importance of the subject, your reference committee did not deem it wise to attempt to properly phrase these concepts.

"We would also recommend that if possible this study be completed at least six weeks prior to the June session and that the new version be published in *The Journal* in order that all interested physicians might have an opportunity to comment thereon."

VETERANS' MEDICAL CARE

The House revised AMA policy on veterans' medical care by endorsing in principle the following paragraph suggested by the Council on Medical Service:

"With respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administration and other federal hospitals that new legislation be enacted limiting such care to veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated."

This action eliminates the temporary exceptions which were made in the June, 1953, policy regarding wartime veterans who are unable to defray the expenses of necessary hospitalization for non-service-connected cases of tuberculosis or psychiatric or neurological disorders. In making the policy change, the House approved this supplementary statement:

"We recognize the laws and administrative extensions of the law that are now in operation. We feel that under the circumstances it will be to the best interests of the public in general, and veterans in particular, if medical societies, county and state as well as national, develop committees to assist in guaranteeing VA hospital admission to service-connected cases. While the

(Continued on Page 68)

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present law exists, we should help assure that veterans whose illness constitutes economic disaster will not be displaced by those suffering short-term remediable ills which, at the worst, constitute financial inconvenience."

In another action concerning veterans, the House passed two resolutions condemning as unlawful the practice of Veterans Administration hospitals which admit patients who are covered by workman's compensation insurance or by private health insurance and which render bills for the cost of their care. Both resolutions requested the AMA to take action to bring about a discontinuance of such practices by VA hospitals, and one of them instructed the Association Secretary to obtain from each state testimony or records of each known case that violates VA Reg. 6047-D1.

RADIOACTIVE ISOTOPES

The House, by rescinding its June, 1951, action, which limited the hospital use of radium and radioactive isotopes to board-certified radiologists, approved a resolution introduced and promoted by the Ohio delegation.

In the June 1955 meeting of the AMA House of Delegates, Dr. Lincke, representing the Ohio delegation, introduced a resolution asking for the rescinding of the resolution adopted in June 1951. Upon recommendation of the Reference Committee, this resolution was not adopted.

In June, 1956, Dr. Lincke again for the Ohio delegation introduced a similar resolution asking that the House of Delegates rescind the action of June, 1951. The resolution was actively supported before the Reference Committee by Dr. William G. Myers and Dr. Florence Lenahan, of Columbus, and on the floor of the House by Dr. Richard L. Meiling.

The House, on the basis of this resolution, directed the Speaker of the House to appoint a committee to study this question and report its findings in November at the Clinical Session. The Speaker appointed the committee with Dr. Meiling as chairman. The committee met and made its report to the House at the Seattle meeting with the result that the House of Delegates adopted a new policy statement which reads:

"(1) In any hospital in which a patient is to receive radium or the products of radium or artificially produced isotopes, there should be a duly appointed Committee on Radium and Artificially Produced Radioisotopes of the hospital professional staff. This committee should include, but not necessarily be limited to, the following qualified physicians: a radiologist, a surgeon, an internist, a gynecologist, a urologist and a pathologist. This committee should have available such competent consultation of other physicians and scientific personnel as may be required by it. Where this is not practicable, the hospital staff should consult the nearest Committee on Radium and Artificially Produced Radioisotopes.

"(2) In any hospital, the use of radium or its products and artificially produced radioactive isotopes for diagnostic or therapeutic purposes shall be restricted to qualified physicians so judged by the Committee on Radium and Artificially Produced Radioisotopes of the professional staff to be adequately trained and competent in their particular use.

"(3) It is recommended that procurement, storage, dosimetry control and inventory of all radioactive isotopes for the use of the hospital staff and radiological safety control be centralized, and, where administratively possible, centralization be located in the Department of Radiology.

"(4) It is recommended that the Board of Trustees assign to the appropriate council or committee the continuous study of the problems of radiological safety control in the use of radium and its products and artificially produced radioactive isotopes for diagnostic or therapeutic purposes."

CLINICAL MEETINGS

Rejecting a resolution which recommended discontinuance of the interim sessions, or clinical meetings, the House adopted a reference committee report which said:

"We believe that the interim sessions should be continued because of the public relations value of these meetings to the Association and the educational value to physicians and the general public in the various geographical areas involved.

"It is the suggestion of the reference committee that maximum attention be given to these potential benefits in selecting a city for the interim meeting.

"It is our further recommendation that the Board of Trustees consider the advisability of holding an Interim Meeting of the House of Delegates in Chicago each November or December and an Interim Scientific Session in November or December of each year in different parts of the United States. The reference committee suggests that the views of the Board of Trustees in this regard be reported to the House of Delegates next June."

To implement educational approaches to the problem of alcoholism, the House approved a statement submitted through the Board of Trustees by the Council on Mental Health and its Committee on Alcoholism. The House also recommended that the statement be brought to the attention of the Council on Medical Education and Hospitals, the Joint Commission on Accreditation of Hospitals and the American Hospital Association. It includes the following:

"The Council on Mental Health urges hospital administrators and the staffs of hospitals to look upon alcoholism as a medical problem and to admit patients who are alcoholics to their hospitals for treatment, such admission to be made after due examination, investigation and consideration of the individual patient. Chronic

alcoholism should not be considered as an illness which bars admission to a hospital, but rather as qualification for admission when the patient requests such admission and is cooperative, and the attending physician's opinion and that of hospital personnel should be considered. The chronic alcoholic in an acute phase can be, and often is, a medical emergency."

COMMITTEE ON MEDICAL PRACTICES

In approving a progress report of the Committee on Medical Practices, the House amended one of its directives to read as follows in order to remove any legal objections:

"The AMA representatives on the Joint Commission on Accreditation of Hospitals be instructed to stimulate action by that body leading to the warning, provisional accreditation, or removal of accreditation of community or general hospitals which exclude or arbitrarily restrict hospital privileges for generalists as a class regardless of their individual professional competence where such policies adversely affect the quality of patient care rendered. Any action taken should be only after appeal to the Commission by the county medical society concerned."

The House also approved a recommendation by the Committee on Medical Practices that a study group be formed to consider the best background preparations for general practice, and it urged that such action be implemented as soon as practicable.

Dr. Edward M. Gans of Harlowton, Montana, was announced at the opening session Tuesday as the 1956 General Practitioner of the Year. The annual award, carrying with it a gold medal and a citation, is presented to a family doctor selected by a special committee of the Board of Trustees for outstanding community service. Dr. Gans, who is 80 years old, has practiced medicine for 51 years and has been in the Harlowton area for the past 44 years.

MISCELLANEOUS ACTIONS

Among many other actions on a wide variety of subjects, the House of Delegates also:

Urged the widest possible publication and distribution of Dr. Murray's presidential address at the opening session (this timely and thought-provoking message to the profession is printed on page 83 of this issue);

Pledged the full support of the Association's initiative and energy to President Eisenhower's people-to-people program as a means of promoting understanding, peace and progress;

Directed the Board of Trustees to continue its investigation of the practicability of developing a statement of AMA policies and to arrange for the periodic publication of revised versions of such a policy statement;

Commended the objectives of the American Association of Medical Assistants and its sincere desire to work closely with the medical profession in improving medical service and medical public relations;

Noted with pride the good work being done by the 74,348 members of the Woman's Auxiliary, as reported to the House by Mrs. Robert Flanders, President;

Directed the Councils on Pharmacy and Chemistry and on Foods and Nutrition to conduct a joint study of all presently available information concerning the fluoridation of public water supplies and to present a documented report of findings and recommendations at the December, 1957, meeting;

Urged all physicians to participate actively in the formulation of medical policy for prepaid medical care plans which are under physician direction or sponsorship;

Changed the By-Laws to extend service membership to reserve officers on extended active duty with the defense forces and the U. S. Public Health Service;

Changed the By-Laws relating to transfer of membership so that an active or associate member of the Association who moves his practice to another jurisdiction may continue his AMA membership by applying for membership in the constituent association in his new jurisdiction, subject to a two-year limit on approval of his application;

Changed the By-laws so that the election of officers may take place at any time on the fourth day of annual session, instead of being restricted to the afternoon of that day;

Passed a resolution calling for the American Medical Association to join with the American Hospital Association and the American Institute of Architects in their proposed study of hospital design and construction:

Approved the principle of a voluntary reduction in the self-assigned quota of interns as printed in the 1956 handbook of the National Intern Matching Program, and

Instructed the Board of Trustees to accentuate cooperation between the American Medical Association and the American Bar Association to the end that a bill of the Jenkins-Keogh type be enacted at the next session of Congress.

At the Tuesday opening session Dr. Murray, on behalf of the American Medical Association, presented a special citation to Ciba Pharmaceutical Products, Inc., for "the service it has performed to the medical profession and to the nation through its weekly television series, 'Medical Horizons.'" At the same session the American Medical Association and four of its constituent societies—California, Arizona, Utah and New Jersey—contributed nearly $300,000 to the American Medical Education Foundation for aid to the nation's medical schools. The AMA announced another gift of $125,000, bringing this year's total contribution to $343,000. The amounts presented by the four states were: California, $132,981; New Jersey, $25,000; Utah, $11,870, and Arizona, $3,695.



Red Letter Dates

For Your 1957 Calendar

It isn't too early to make Hotel Reservations Now for the 1957 ANNUAL MEETING of the OHIO STATE MEDICAL ASSOCIATION. The place is COLUMBUS: the dates, MAY 14, 15 and 16, 1957.

Here is a list of leading downtown Columbus hotels and a hotel reservation blank for convenient mailing.

NAME AND LOCATION	SINGLE	DOUBLE	TWIN
NEIL HOUSE, 41 S. High St.	$ 6.00-11.00	$ 9.00-11.00	$11.00-14.00
DESHLER-HILTON HOTEL, W. Broad & N. High	$ 5.00-13.50	$11.00-18.50	$11.00-18.50
FORT HAYES HOTEL, 31 W. Spring St.		$ 9.00 up	$ 9.00 up
SENECA HOTEL, 361 E. Broad St.	$ 4.00- 7.00	$ 6.00- 9.00	$ 9.00-12.00
HOTEL SOUTHERN, S. High & E. Main Sts.		$ 8.00 up	$ 9.00 up
VIRGINIA HOTEL, Gay & Third Sts.	$ 7.00- 8.00	$10.00-12.00	$11.00-14.00

Persons who desire additional accommodations are advised to specify their needs to the hotel of choice.
(All Rates Subject to Change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager ..... Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 14, 15, 16, 1957, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....

☐ Twin Bed Room with Bath ☐ Other

Arriving May ..... at ..... A. M. ..... P. M.

PLEASE VERIFY MY RESERVATION

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New Setting and New Features for the 1957 Annual Meeting



The new Veterans Memorial Building in Columbus will be the setting for the 1957 Annual Meeting of the Ohio State Medical Association, May 14, 15 and 16. It is located on the west bank of the Scioto River and faces south on Broad Street.

The beautiful and extremely functional new structure provides an "under one roof" center for the Annual Meeting, and is centrally located in Columbus. It has ample floor space for what promises to be another outstanding Scientific and Educational Exhibit and Technical Exhibit. It offers meeting rooms well suited for the various scientific programs.

In addition to the regular scientific and clinical presentations, "something different" is being provided for OSMA members at the 1957 meeting.

This "something different" will be presentations by top experts in the medical-legal, investments, and estate planning fields.

They will offer valuable information and experienced observations regarding those subjects, which are occupying more and more of the attention of the medical profession, on both a professional and a personal basis.

On Tuesday, May 14, a general session will be devoted to "The Doctor and the Law," when a panel of outstanding legal minds will discuss matters of the law as they apply to the medical profession.

On Wednesday, May 15, a special AMA film, "The Medical Witness," depicting the correct way and the wrong way for the physician to give medical testimony in court, will be shown. Following the film, a panel of legal experts will answer questions.

On Thursday, May 16, a feature will be "Advice to Physicians on Investments" and "Advice to Physicians on Estate Planning," consisting of presentations by recognized authorities in those fields. Also on Thursday, a member of the AMA Legal Department will speak on "The Malpractice Problem" and will answer questions.

All of the aforementioned presentations are scheduled for general sessions since they are subjects of interest to all members of the medical profession, regardless of specialty or field of interest.

Medicare Program in Ohio . . .

Became Operable Dec. 7; Doctor's Bills Now Being Paid by Second Army Surgeon; Selection of Insurance Company as Administrator Is Imminent

HERE were developments in the Medicare Program (Uniformed Services Dependents Medical Care Program) so far as Ohio is concerned on December 20 when this issue of *The Journal* went to press and since the December 7 issue of *OSMAgram* was sent to all members.

The Mutual Benefit Health and Accident Association of Omaha, Nebraska (Mutual of Omaha), will in all probability be designated by Major General Paul I. Robinson, M. C., executive director, Office for Dependents' Medical Care, as fiscal agent and administrator for the program in Ohio.

Consummation of a contract with Mutual of Omaha to handle administrative details in Ohio, including the making of payments to physicians in accordance with the Medicare schedule of allowances for Ohio, appeared imminent at press time.

OSMA POLICY

As members of the OSMA probably know by this time, the Association declined to contract as fiscal agent and administrator for the program in Ohio. The reasons for this as published in the December issue of *The Journal* and *OSMAgram* were: (1) The contract would have committed all members of the Association to the government fees and not allowed each physician to decide for himself whether or not the government's fees should be accepted as payment in full for his professional services to dependents; (2) would have required the OSMA to perform administrative and other duties for the government which might create serious legal and financial problems for the Association.

At the same time the Association did offer to cooperate in the administration of the Medicare Program in Ohio and to assist in keeping Ohio physicians informed about the program—activities which the Association carries on daily with regard to other government medical programs operable in Ohio.

NO DELAY IN PROGRAM IN OHIO

This decision of the Association has not in any way delayed operation of the Medicare Program in Ohio. Dependents are now being cared for by Ohio physicians. The dependent has free choice of physician. A physician may decide for himself whether or not to accept the case. The Association has not committed any physician to participation or to any fee schedule, leaving the decision to the individual physician. It has not told any physician not to take a Medicare case, leaving that to the individual physician.

Mutual of Omaha, which is being considered to administer the medical phases of the Medicare Program in Ohio, was selected several weeks ago to administer the hospital administrative details in 17 states, not including Ohio. Hospital administrative details of the program in Ohio are being handled by the various Ohio Blue Cross plans.

ADMINISTRATIVE MATTERS

If and when Mutual of Omaha takes over Medicare administrative work in Ohio, physicians, who care for eligible dependents under the program and after the company takes over and desire to bill the government for such services, will send their bills to the Mutual of Omaha office at Omaha, Nebraska. The company will make payments according to the Medicare Schedule of Allowances for Ohio and will be reimbursed later by the government.

After Mutual of Omaha or any other agency takes over administrative details, the Office of the Surgeon, Second Army, Ft. George G. Meade, Maryland, will withdraw from the picture. That office has been handling details, including payment of Ohio physicians' bills, since December 7, when the Medicare Program became operable and pending selection of a fiscal agent and administrator in Ohio.

SCHEDULE OF ALLOWANCES

One of the jobs of the fiscal agent and administrator will be to make available to Ohio physicians copies of the Schedule of Allowances under which Ohio physicians who care for dependents under the program will be paid. The schedule consists of about 1,400 items. The amounts are the maximum amounts which the government will pay.

Until they can secure a copy of the Schedule of Allowances, Ohio physicians may wish to delay billing. On the other hand, if they desire to bill immediately, they will have to list their regular average charge which, of course, will be cut if it is over the schedule.

The Schedule of Allowances which will be applicable to Ohio was drafted by the Office of Dependents Medical Care, Washington. It was reviewed by the Medicare Committee of the Ohio State Medical Association. Approximately 25 changes were suggested, most of which were ap-

proved by General Robinson's office and appear in the schedule.

NO FORMAL AGREEMENT

There is no formal agreement between the government and the OSMA regarding the Schedule of Allowances for Ohio. However, there is a mutual understanding that the Association and the Office of Dependents' Medical Care will cooperate on this detail. The Association has offered to make suggested changes in the schedule as the need for changes arises. The government has requested the Association to do this and has consented to consider changes proposed by the Association. As pointed out, certain changes proposed by the Association already have been made.

FORM TO BE USED

Form 1863, prepared for Medicare Program, should be used by any physician who expects Government to pay him for services to military dependents. On it he should list data regarding services and his charges for services. Instructions for filling out form appear on back of form. The form also is used by hospitals, dentists and nurses, so some of instructions may sound confusing to physicians.

A supply of Form 1863 has been sent to the Secretary of each County Medical Society in Ohio where members may obtain copies. Hospitals should have copies, also.

If a physician signs Form 1863, he subscribes to the following statement: "I will accept the amount listed in the Dependents Medical Care Program Schedule of Allowances or the amount shown in Item 24 (i. e., charge listed by physician) whichever is less, as full payment for the services described above."

POLICY OF THE GOVERNMENT

In a letter dated November 19 General Robinson stressed the fact that the Government regards Medicare as a full-payment plan, meaning a physician will be expected to accept what the Government will pay as payment in full of his bill.

General Robinson's letter is appended to this article.

WHAT IS COVERED; WHAT ISN'T

It is assumed that later on Ohio physicians will be supplied with a manual containing instructions and regulations pertaining to the program. Until this is available, Ohio physicians should keep the following information on file for reference:

Military dependents may submit as identification their post exchange card, the combined post-exchange-commissary-military care card, or the standard military dependent identification card. After next July 1 the only identification honored will be a special Defense Department Medicare card.

Medicare Washington office says no plans for authorizing payment for drugs, medicinals or other medical supplies, except those furnished while hospitalized or those administered directly by a physician.

This point is very important: Ordinary routine home and office calls are not generally covered. The dependent must pay the first $15.00 of the physician's fee in the comparatively few cases which can be cared for under the program outside the hospital. (See No. III, f, below.) In other words the program is primarily a program of medical care for hospitalized cases. The exceptions will be found in the detailed explanation which follows.

DETAILED EXPLANATIONS

Here is an explanation of the program prepared by the government and which appears on the back of Form 1863:

I. Under the provisions of the Dependents' Medical Care Act, **dependent spouses and children** of members of the Uniformed Services *(Army, Navy, Air Force, Marine Corps, Coast Guard, and the Commissioned Corps of the Public Health Service and Coast and Geodetic Survey)* **on active duty or active duty for training under orders not specifying a period of thirty days or** less are eligible to receive certain medical care from civilian sources at Government expense.

III. Medical services authorized to be provided eligible spouses and children may include:

a. Hospitalization in semi-private accommodations up to 365 days for each admission, including all necessary services and supplies furnished by the hospital during hospitalization.

b. Medical and surgical care during a period of hospitalization.

c. Complete obstetrical and maternity care. Normally the government restricts payment to one physician within any one trimester of maternity care or for post partum care. Exceptions may be granted in cases wherein a change of physician was necessary due to circumstances beyond the control of the patient, i. e. Permanent change of sponsor's duty station; change of patient's residence involving a considerable distance; death or disability of physician. Patient will pay $15.00 to physician in event of home delivery. Such payment will not be made to physician if patient is hospitalized for post partum care, or if patient has been hospitalized for that pregnancy or a direct complication thereof with a resultant $25.00 payment to the hospital.

d. Services required of a physician prior to and following hospitalization for a bodily injury or surgical operation. Patient will normally pay charges for diagnostic tests or procedures in excess of $75.00 prior to hospitalization and in excess of $50.00 following hospitalization. (Patient will pay for all such tests prior to hospitalization for other conditions)

e. Diagnostic tests and procedures including laboratory, pathology, and x-ray examinations during hospitalization when ordered by the attending physician.

f. Treatment of fractures, dislocations, lacerations and other wounds when patient is NOT hospitalized. Patient will normally pay the first $15.00 of such physician fee plus cost of

diagnostic tests or procedures in excess of $75.00.

g. Treatment in a hospital of acute emergencies of any nature which are a threat to the life, health, or well-being of the patient including acute emotional disorders pending arrangement for care elsewhere.

h. Dental care which is a necessary adjunct to medical or surgical treatment rendered in a hospital to a dependent who is a hospital inpatient and concurred in by the attending physician.

IV. Medical services **not** authorized from civilian sources include:

a. Chronic diseases, except for acute exacerbations or acute complications.

b. Nervous and mental disorders, i. e., neuroses, psychoneuroses, psychopathias or psychoses *(except in III g above).*

c. Elective medical and surgical treatment desired by the patient which in the opinion of cognizant medical authority is not medically indicated, e. g. surgery solely for cosmetic purposes.

d. Domiciliary type care, e. g. personal care contradistinct to active and definitive treatment.

e. Outpatient care except for the payment of one visit to a physician initially responsible who transfers full care to another physician upon patient's hospitalization and as indicated in III c, d, and f above.

f. Ambulance service.

g. Drugs, medicinals or other medical supplies except those furnished as an in-patient or those administered directly by a physician while providing authorized care.

TEXT OF ROBINSON LETTER

Following is the text of General Robinson's letter explaining that the government considers the Medicare Program a payment in full type program:

"It has been brought to my attention that some of the persons with whom we have negotiated contracts under the Dependents' Medical Care Act are of the opinion that the Program is not one of full service coverage. This concept may have arisen because the Act itself is not specific regarding this matter. It may also have arisen either because certain fees are stipulated to be paid by the patient or because the contract allows for unusual or difficult cases an additional fee payable by the Government to the physician if he makes proper request under a special report.

"Upon inquiry, I have been assured that members of the negotiating teams have not indicated the contract is other than for full coverage. Further, no instance has been found where any member of the negotiating teams has, in any way, intimated that the Dependents' Medical Care Program is not one of full coverage.

"In order to clarify this matter and to avoid any improper interpretation of the Dependents' Medical Care Act with regard to payments to physicians under a Schedule of Allowances as provided in our contracts, the position of the Department of Defense as is being carried out by my office is submitted for your guidance:

"a. It is intended that civilian medical care authorized under Public Law 569, 84th Congress, will be on a basis comparable to that provided in uniformed services medical facilities. Except for specified amounts to be paid by the patient, the services which are provided under the law will be furnished by physicians participating in the program who will receive payment in full from the Government in accordance with the published Schedule of Allowances or under a special report as the case may be. In most instances, this means that the physician participating in the program will receive payment for his usual charge or the amount established in the local schedule of allowances, whichever is less.

"b. Section 5, paragraph 507b, of the Joint Directive promulgated by the Secretary of Defense and the Secretary of Health, Education, and Welfare provides as follows: "The Executive Agent (Secretary of the Army) shall be responsible within the continental United States, Alaska, Hawaii, and Puerto Rico for the following:

"(1) Preparation of the terms and placement of the contract or contracts to be established to include but not limited to:

"a. Local schedules of allowances to be used **in full payment** of bills presented by physicians and surgeons."

A copy of this Joint Directive is an integral part of every contract and there is no question that the contract provides for full service coverage.

"c. There may be unusual instances in which the physician will believe that an allowance greater than that prescribed in the local schedule of allowances is justified. In such cases, the physician should look to the Government for additional payment, and not to the patient. Provision is made for the physician to submit a special report to his state medical society and in turn to the Government as a request for additional payment. Such additional payment will be made upon approval by the medical society's review board and by the Government's contracting officer."

Heart Group's Scientific Council Sets Meeting

The Central Ohio Heart Association Scientific Council is scheduled to meet at 10 a. m., January 23, in Room M-100, Starling-Loving Hospital, Ohio State University.

At that time, a panel is to discuss "Prevention and Management of Thrombotic-Embolic Complications in Cardiac and Peripheral Vascular Disease," with panelists being Drs. Wiley L. Forman, George I. Nelson and Norman O. Rothermich, all of Columbus, Philip W. Smith, Marion, and Dwight E. Harken, Boston, Mass.

Following a luncheon, Dr. Dwight E. Harken, an associate clinical professor of surgery at Harvard Medical School, one of the foremost cardiovascular surgeons in the nation, will speak on "The Surgical Approach to Coronary Artery Disease." At 3 p. m., Dr. Emmerich von Haam, chairman, Ohio State University Pathology Department, will conduct a cardiac clinical pathology conference, and at 4 p. m. a business session will be held.

Three films recently were added to the AMA Motion Picture Library for use by state and county medical societies, namely "Alcohol and the Human Body"; "Heart Disease—Its Major Causes"; and "Tobacco and the Human Body."

Further information on any of these films may be obtained from the AMA Motion Picture Library.

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians: Reports of Developments in Medical and Health Fields: Activities of Agencies

Food and Drug Administration's medical division has scheduled conference on question of regulation of over-counter sales of Vitamin A supplements. Toxic effects found in intake over 50,000 units daily.

* * *

Air Force expects to have completed at end of 1958 new Aero Medical Center, $8.8 million project, at Brooks Air Force Base, San Antonio, Tex., "to conduct more extensive research into the medical aspects of supersonic flights problems," and to expand aviation medicine teaching facilities.

* * *

Selective Service plans to call up 450 physicians in February, 250 for Army and 200 for Air Force. In March, Congress is slated to start hearings on extension of doctor draft, scheduled to expire July 1 of this year. Selective Service hopes to meet the quota of 450 doctors from those under 37 years of age. Current program was started during Korean War and has brought over 10,000 physicians into the services.

* * *

Civil Service Commission is making a new effort to attain a federal employees health insurance plan, one combining features of both basic and major medical expense coverage. Some officials believe, after repeated failures, plan can be drawn to satisfy employees' unions, commercial companies, Blue Cross and Blue Shield. More optimistic officials see Congress enacting a law by next July, provided combined basic-major medical plan can be agreed on.

* * *

State and territorial health officers recommended at annual meeting continuation of Salk polio vaccine grants program for another year. Program, scheduled to expire June 30, is one in which government gives states money to aid in setting up inoculation program.

* * *

Army Surgeon General's Office has announced that Army's first formal residency training program will begin July 1. Regular Army Medical Corps officers or qualified civilian physicians who will accept commission in the Regular Army are eligible to participate. The residency is a three-year program.

* * *

House hearings on medical education, slated for December, were not held, mainly because of death of committee chairman, Rep. Percy Priest. Last session of Congress saw unsuccessful efforts on House floor to extend grants to medical schools for construction of classrooms. Congress decided more study was in order, thus the hearings. Witnesses were to represent the professions, medical schools and groups utilizing services of doctors.

* * *

Small business Administration has ruled that to be eligible for government loans, a clinic must be operated in conjunction with and as a part of a proprietary hospital which is run for profit; or, the clinic itself must be a licensed hospital or considered a hospital by state authorities.

* * *

Special advisory committee named by Health, Education and Welfare Secretary Folsom to study ways of cutting hospital costs for long term patients has voted to launch a series of pilot projects in an unspecified number of hospitals, with emphasis on three categories of patients: those needing only diagnostic services and facilities, those convalescing from acute illness, and the chronically ill.

* * *

Department of Commerce reports 1956 hospital construction lagged nine per cent behind 1955, excluding December figures, while total construction in all fields ranged three per cent ahead of 1955.

* * *

Federal Hospital Council in December approved allocation of $109,439 in Hill-Burton funds to support five research projects, and approved six other projects to be financed from other Federal appropriations.

* * *

Health, Education and Welfare Secretary Folsom, speaking before National Press Club, reaffirmed its support of reinsurance but said it may be more practical to get Congress to enact a bill permitting health insurance plans to pools risks in order to provide expanded benefits. He also expressed the hope that government will realize the "serious plight of medical schools" and provide funds to improve their teaching and research facilities.

* * *

The War Orphans Education Program (Public Law 634) is a program of financial aid for the education of young men and women whose parents—World War I or II or Korean veterans—died of injuries or diseases resulting from their military service. Details may be obtained from the nearest Veterans Administration office.

WC Fee Bills and Signatures . . .

Distinctive Signatures Are a Pride to Their Owners but They Also Hold Up Payment of Many Doctors' Workmen's Compensation Fee Bills

OHIO doctors who frequently submit fee bills to the Bureau of Workmen's Compensation are advised to use a rubber name stamp as well as their signature on fee bills. That advice comes from Clark C. Grubbs, assistant chief deputy claims administrator of the Bureau.

"We are still receiving many fee bills on which the signature of the doctor is illegible. In the past years, hundreds of man hours have been spent attempting to secure the proper name of the doctor from the various directories in our office. Our examiners are instructed, when a signature is not deciphered, to mark on the fee bill 'signature illegible' and dispose of the claim," Mr. Grubbs said.

The remedy for the situation is very simple if the doctor will obtain a rubber stamp carrying the doctor's name and full address. Mr. Grubbs pointed out, however, that a stamped signature must be personally signed by the doctor as the fee bill is a legal document requesting funds from the State.

The Bureau's examiners then will know definitely to whom payments are to be made.

Mr. Grubbs suggested that no inquiry be made as to non-payment of fee bills until they have been filed for six months. He said most bills are paid much sooner but that period allows time for obtaining additional information and investigation, if such are required. However, immediate inquiry should be made at the end of six months if a fee bill is unpaid.

Mr. Grubbs said many doctors delay such inquiries for several years and often find that the original fee bill has never reached the file of the Bureau of Workmen's Compensation, and payments may not be considered if more than two years have elapsed.

JOHN M. DOE, M. D.
1234 Fifth Street
ANYTOWN 3, OHIO

By.....
(Signature)

This is a model stamp suggested by Clark C. Grubbs, assistant chief deputy claims administrator, Ohio Bureau of Workmen's Compensation, for use by doctors on fee bills to avert delay of payment because of illegible signature. He cautioned that actual signature also is required in order that the fee bill he a legal document.

A form of inquiry has been mimeographed for their own use by many doctors throughout the state, Mr. Grubbs said, and recommended that others follow the same procedure. A copy of this form is shown accompanying this article.

Mr. Grubbs said one of the big problems of the doctor, especially the general practitioner, is

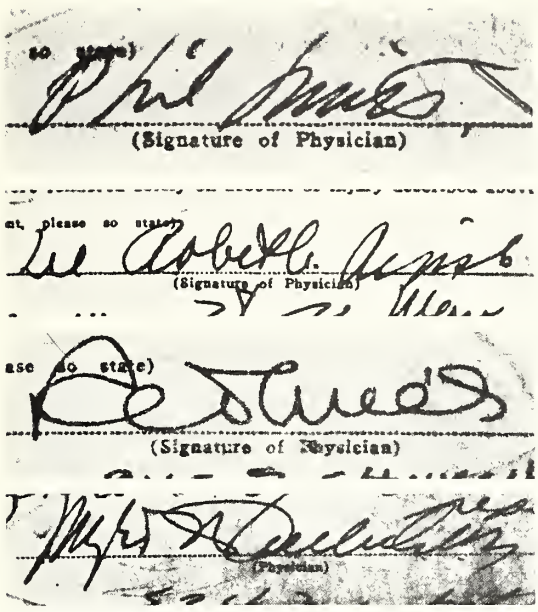
(Name and address of Doctor, Hospital or other parties rendering services)

Kindly furnish the status of the fee bill in the following claim:

Claim No.	Name	Date of Service	Amount

(LIST ONLY ONE CLAIM TO A SHEET)
(NOT TO BE USED AS A FEE BILL)

This is a model form of inquiry recommended by the Bureau of Workmen's Compensation for Ohio physicians desiring to make an inquiry concerning a claim. The Bureau recommends that doctors have forms mimeographed, and requires one inquiry only on each form.



These are some of the signatures of Ohio doctors on fee bills submitted to the Ohio Bureau of Workmen's Compensation. According to the assistant chief deputy claims administrator, Clark C. Grubbs, hundreds of man hours have been spent in attempting to decipher signatures on fee bills. Examiners now are instructed to stamp such bills "signature illegible" and to dispose of the claim.

with cases involving small employers or out-of-town contractors. He advises that such cases be followed up immediately, and that the doctor should insist that the employer file a claim immediately.

Many doctors have found it well worth the effort to send their office secretaries to the Bureau in Columbus to learn thoroughly the procedure for filing fee bills. He also said he is available to address groups of office personnel on the matter for submitting fee bills.

Mr. Grubbs further pointed out that he and other representatives of the BWC welcome invitations to address medical society meetings and particularly stress the importance of having office personnel present at those meetings.

It is valuable to have office employes present because they handle much of the paper work. He also suggested that special group meetings of personnel be arranged to hear a BWC representative discuss the bureau's procedures, rules, paper work and related items.

He may be contacted at the Claims Department, Bureau of Workmen's Compensation, State Office Building, Columbus 15.

New Film on AMA Activities

AMA's new 30-minute color movie designed to acquaint physicians with the services and activities of their national organization is ready for distribution. Entitled "The Case of the Doubting Doctor," the film was prepared primarily for medical society meetings.

No Need To File X-Ray Films, W. C. Bureau Decides If Two Conditions Are Met

It will no longer be necessary for physicians and hospitals to furnish the Bureau of Workmen's Compensation with x-ray films in order to obtain payment for x-ray services in industrial cases, provided hospitals and physicians are willing to hold the x-ray films for a period of 10 years. Also, they must continue to send a detailed, signed interpretation of x-ray findings with fee bills. The Bureau still requires that x-ray films, together with signed interpretations, be submitted with fee bills involving silicosis or berylliosis.

Complete text of the Bureau's order, effective immediately follows:

"By direction of Joseph J. Scanlon, Administrator of the Bureau of Workmen's Compensation, and further by way of resolution by members of The Industrial Commission of Ohio, and effective with the date of execution of this order, employees of the Bureau and Commission are authorized to pay, in accordance with the General Medical Fee Schedule, the fee bills of doctors and hospitals who furnish x-ray service, provided said doctors and hospitals submit with such fee bill a detailed, signed, interpretation of x-ray findings. It is further provided that it will not be necessary for said doctors and hospitals to file x-ray films.

"It is further directed that doctors and hospitals shall be required to file x-ray films, together with their interpretations, in all cases involving silicosis or berylliosis.

"It is further directed that payment of x-ray fee bills, without accompanying films, shall be conditioned upon the willingness of the doctors and hospitals involved to hold and have available said x-ray films for a ten-year period, and to deliver them to the duly authorized representatives of the Bureau or Commission upon their request."

Postgraduate Assembly

The first American Post-Graduate Assembly in Fertility and Sterility, sponsored by the New York Medical College and Metropolitan Medical Center, will be held in New York City at the College and affiliated hospitals May 18-31. Dr. Ralph E. Snyder, dean of the College, 1249 Fifth Avenue, is in charge of registrations. Tuition is $150.

Sectional meetings of the American College of Surgeons will be held in the following cities during 1957: San Juan, Puerto Rico, January 16-18; New Orleans, La., February 4-7; Seattle, Wash., February 28-March 2; Washington, D. C., March 18-20; Toronto, Ontario, March 25-27; St. Paul, Minn., April 8-10.

Course on Diabetes . . .

American Diabetes Association Will Sponsor Three-Day Course on Diabetes Mellitus at OSU in Columbus, January 30-February 1

THE Fifth Postgraduate Course in Diabetes and Basic Metabolic Problems will be offered by the American Diabetes Association at the Ohio State University campus in Columbus, January 30 - February 1. All lectures will be held in the Conference Theater of the Ohio Union, High Street at 13th Avenue on the campus. The Deshler-Hilton Hotel will be the headquarters hotel.

Director of the course will be Dr. Geo. J. Hamwi, associate professor of medicine, and head of the Division of Endocrinology and Metabolism, OSU College of Medicine. Associate director will be Dr. Thomas P. Sharkey, of Dayton, assistant clinical professor of medicine at OSU, and consultant in internal medicine and pathology at Miami Valley Hospital, Dayton.

The course is open to members of the medical profession. Registration fee is $40 for members of the American Diabetes Association and $75 for nonmembers. Special fees will apply to fellows and residents, and interns will be admitted free. Additional information may be obtained from J. Richard Connelly, Executive Director, American Diabetes Association, Inc., 1 East 45th Street, New York 17, N. Y.; or from Dr. Hamwi.

The American Academy of General Practice will give 22 hours postgraduate credit for the course.

Following are highlights of the program:

WEDNESDAY, JANUARY 30

Registration opens 8:00 a. m.

Program begins 9:30 a. m.

Pathophysiology of Diabetes Mellitus

Chairman of morning program will be Dr. Frederick W. Williams, New York Medical College, with the following lecturers participating: Dr. Rachmiel Levine, University of Chicago; Dr. William C. Stadie, University of Pennsylvania School of Medicine; Dr. Charles H. Best, University of Toronto, Canada; and Dr. Stefan S. Fajans, University of Michigan.

Luncheon by subscription. Panel discussion of the foregoing topic with the lecturers participating; Dr. Henry T. Ricketts, University of Chicago, moderator.

WEDNESDAY AFTERNOON

Diagnosis of Diabetes Mellitus

Chairman of afternoon session, Dr. John A. Reed, George Washington University. Lecturers: Dr. Cecil Striker, University of Cincinnati College of Medicine; Dr. Alexander Marble, Harvard Medical School; Dr. Blair Holcomb, University of Oregon Medical School, and Dr. E. Perry McCullagh, Cleveland Clinic. Question and Answer period.

WEDNESDAY EVENING

Social hour by subscription, Deshler-Hilton Hotel, followed by banquet. Dr. Russell B. Roth, Erie, Pa., will present the subject, "Public Relations and the Physician."

THURSDAY, JANUARY 31

Program begins 9:00 a. m.

Clinical Management of Diabetes Mellitus

Chairman of morning session, Dr. Franklin B. Peck, Sr., University of Indiana; lecturers: Dr. Joseph T. Beardwood, Jr., University of Pennsylvania; Dr. Herbert Pollack, New York University; Dr. Garfield G. Duncan, Jefferson Medical College.

Oral Hypoglycemic Agents

Dr. Levine and Dr. Arthur R. Colwell, Sr., Northwestern University Medical School.

Luncheon by subscription, followed by panel discussion on the foregoing topic; Dr. Hamwi, moderator, with the following panel: Drs. Coldwell, Levine, Duncan, and Dr. Robert M. Kark, University of Illinois College of Medicine; and Dr. William R. Kirtley, Indiana University.

THURSDAY AFTERNOON SESSION

Objective of Treatment of Diabetes Mellitus

Chairman: Dr. Ricketts.

Panel Discussion—Dr. Beardwood, moderator; Drs. Marble, Harvey C. Knowles, Jr., University of Cincinnati; Randall G. Sprague, Mayo Foundation; Henry B. Mulholland, University of Virginia; Christopher J. McLoughlin, Emery University School of Medicine; and John A. Reed, George Washington University.

Conditions Complicating Diabetes Mellitus

Dr. Best

THURSDAY EVENING

Social Hour, 6:30 p. m. at the Deshler-Hilton Hotel, guests of the Life Insurance Companies of Columbus.

FRIDAY, FEBRUARY 1

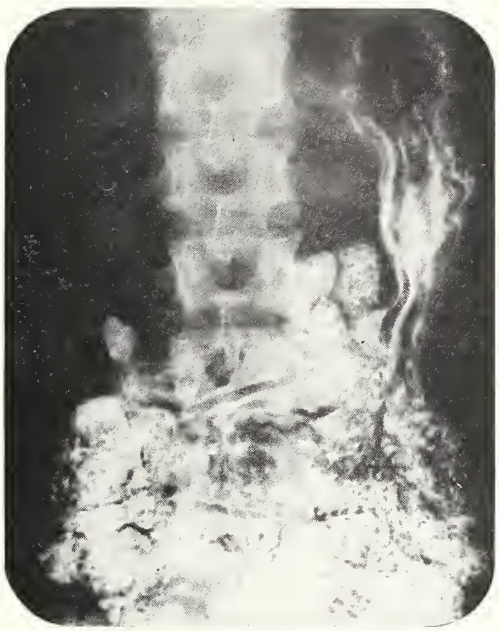
Conditions Complicating Diabetus Mellitus (continued)

Chairman of morning session, Dr. William H. Olmstead, Washington University School of Medicine, St. Louis. Lectures by the following: Dr. T. S. Danowski, University of Pittsburgh; Dr. Sprague; Dr. Frederick W. Williams; Dr. Roger

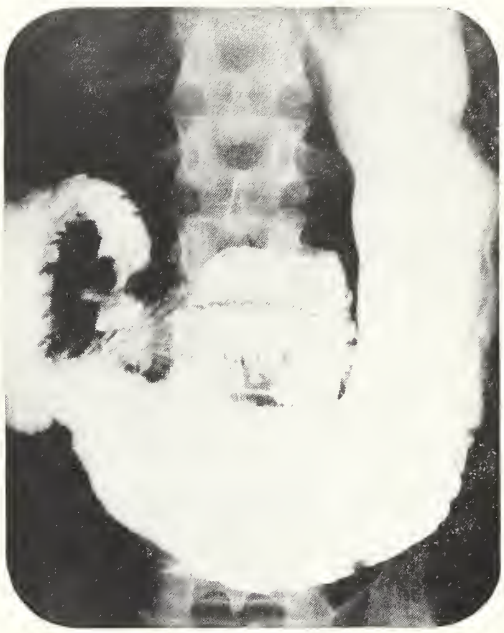
(Continued on Page 80)

DIAGNOSTIC AID

Reduced Hypermotility with Pro-Banthine® Improves Visualization



*Posterior-anterior film: definite hyperperistalsis with poor duodenal visualization.**



Posterior-anterior film after 15 mg. of Pro-Banthine intramuscularly: chronic duodenal ulceration clearly disclosed.

The same anticholinergic action which has made Pro-Banthine (brand of propantheline bromide) the outstanding therapeutic agent in peptic ulcer has also proved valuable in diagnosis.

By controlling the hypermotility, Pro-Banthine may permit delineation of a lesion otherwise not clearly visualized.

The technic is simple: If the first set of films shows hypermotility but no filling defect is demonstrable, reexamination is done a few minutes after intramuscular injection of 15 mg. or a half hour after oral administration of 30 mg. of Pro-Banthine.

This procedure has the additional advantage of demonstrating the patient's response to a given dosage of the drug.

G. D. Searle & Co., Chicago 80, Illinois, Research in the Service of Medicine.

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*Roentgenograms courtesy of I. Richard Schwartz, M.D., Kings County Gastrointestinal Clinic, Brooklyn, N.Y.

SEARLE

D. Williams, Ohio State University; and Dr. Kark.

Luncheon by subscription.

Discussion of **Hypoglycemia**, with a panel consisting of Dr. McCullagh, moderator; Drs. Fajans, Knowles, and Howard F. Root, Harvard Medical School.

FRIDAY AFTERNOON SESSION

Chronic Complications of Diabetes Mellitus

Chairman, Dr. Mulholland. Lecturers: Drs. Bloodworth, Root, and Ricketts.

Clinical Pathological Conference, Drs. Danowski and Dr. Emmerich von Haam, professor and chairman of the Department of Pathology, Ohio State University.

Urges Stepped-Up Polio Immunization Program; 35 Per Cent of Ohio Children Unprotected

Dr. Ralph E. Dwork, director of the Ohio Department of Health, urged a stepped-up program for immunizations with Salk vaccine in view of the increasing supply of vaccine, in a statement to local health commissioners of Ohio.

"It seems apparent that the public has become somewhat apathetic in its attitude toward the inoculation program during the winter months," the health director said.

"Based on records available in this office, it is estimated that approximately 35 per cent of the children between the ages of zero through 19 have not even received the first shot of poliomyelitis vaccine," Dr. Dwork said, emphasizing that the biologic has definitely been demonstrated to afford protection against paralytic poliomyelitis.

The Ohio Department of Health is continuing to purchase vaccine with the use of available federal funds for distribution to local health departments. It is pointed out, however, that vaccine purchased with federal funds may be administered only to persons in the priority group, which is age 0 through 19 and expectant mothers. This restriction is written into the Congressional Act authorizing the allocation of federal funds for the purpose, and it can be changed only by the Congress.

Dr. Dwork urged that public information programs be directed toward having people of all ages obtain immunization through their personal physicians.

"We sincerely believe that if everyone takes advantage of immunization against poliomyelitis, the number of cases in Ohio can be reduced to a minimum next summer," Dr. Dwork said.

Do-it-yourself activities are responsible for only a small percentage of fatal home accidents. In a study of males from 15 to 64 who died of accidents in and around the house, only 6 per cent were engaged in repair, maintenance or improvement work.—Metropolitan Life.

New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since October 1, 1956. This list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ALLEN COUNTY
- Kendall O. Burns, Lima
- Edward K. Steinkopff, Lima

CLARK COUNTY
- Ernest Anderson, Jr., Springfield

CLINTON COUNTY
- John O. Smith, Wilmington

COLUMBIANA COUNTY
- Peter R. Cibula, Lisbon

CUYAHOGA COUNTY
- Robert L. Adamich, Cleveland
- Leslie Bandy, Solon
- Max Benis, Cleveland
- Charles S. Berry, Cleveland
- Elmars M. Bitte, Cleveland
- Peter A. Bruch, Cleveland
- Maxine R. Cammarn, Cleveland
- John H. Davis, Cleveland
- John D. DesPrez, Jr., Cleveland
- John J. P. Gulan, Cleveland
- William Hoffman, Cleveland
- Benjamin Kaufman, Cleveland
- Harold F. Knight, Jr., Cleveland
- Clifton V. Lee, Cleveland
- Donald McCord Lynn, Jr., Cleveland
- Armand Mandel, Cleveland
- Janis Mazkalnins, Cleveland
- Hugh F. McCorkle, Cleveland
- Marjorie McDonald, Cleveland
- Victoria Miknis, Cleveland
- Wolfgang Nebehay, Cleveland
- Thomas E. Netherton, Cleveland
- Gordon F. Ogram, Cleveland
- Paul Pipik, Cleveland
- Edward J. Quilligan, Cleveland
- George L. Sackett, Jr., Cleveland
- Ernest H. Schroeder, Cleveland
- Sidney L. Schuchter, Cleveland
- William A. Sibley, Cleveland
- Albert H. Silverberg, Cleveland
- Dwight S. Spring, Jr., Cleveland
- Enhew Sycz, Cleveland
- Harvey A. Tretbar, Cleveland
- Jack V. Wise, Cleveland
- Ervin F. K. Wiktorin, Cleveland

FRANKLIN COUNTY
- Michael A. Anthony, Columbus
- Byron Blake, Grove City
- John G. Boutselis, Columbus
- Donald H. Burk, Westerville
- Robert R. Kessler, Columbus
- Hermann A. Sailer, Grove City
- Jack E. Tetirick, Columbus

HAMILTON COUNTY
- Taylor Asbury, Cincinnati
- Caesar S. Bassette, Jr., Cincinnati
- Z. Charles Fixler, Cincinnati
- Eli I. Schneider, Cincinnati
- William K. Schubert, Cincinnati
- Samuel P. Todd, Jr., Cincinnati

LORAIN COUNTY
- Warren Sheldon, Lorain

MIAMI COUNTY
- Mark F. Hance, Troy
- Glen S. Hogle, Troy

MONTGOMERY COUNTY
- Donald A. Buck, Dayton
- Peter A. Granson, Dayton
- Joseph J. Larkin, New Lebanon
- Edward J. Leschansky, Dayton
- C. Nelson Melampy, Dayton
- Gerald F. Nangle, Dayton
- Eric F. Routley, Dayton
- Alvin D. Shelton, Miamisburg

MUSKINGUM COUNTY
- Bogomir Stoycic, Nashport

RICHLAND COUNTY
- Robert Wm. Jones, Mansfield

SUMMIT COUNTY
- William W. Reynolds, Akron

TRUMBULL COUNTY
- Richard W. Aubrey, Warren
- John R. Somple, Girard

TUSCARAWAS COUNTY
- Thomas E. Ogden, Gnadenhutten

WASHINGTON COUNTY
- Joseph E. LaBarre, Marietta

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

March 5, 6, 7 and 8, 1957

Palmer House, Chicago

DAILY HALF-HOUR LECTURES BY OUTSTANDING TEACHERS and SPEAKERS
on subjects of interest to both general practitioner
and specialist

PANELS ON TIMELY TOPICS

DAILY TEACHING DEMONSTRATIONS

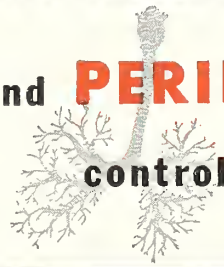
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Mental Hygiene . . .

With a Good Start in the Right Direction. Some Suggestions for the Future of the State Agency Are Offered by Dr. Porterfield on Leaving

A BLUEPRINT for the immediate future of the Ohio Department of Mental Hygiene and Corrections was suggested by Dr. John D. Porterfield as one of his last acts as Department director before vacating the post to become assistant to the U. S. Surgeon General.

The blueprint is contained in the November edition of *Motive*, official publication of the Department, and was presented by Dr. Porterfield under the heading "The Director's Final Letter."

Dr. Porterfield's suggestions as to the future course of the Department were based on "over two years' close study of the practical operation of the department and its programs," and were presented "only as the personal opinions of the writer and should be given only that weight." His blueprint included the following points:

SHOULD KEEP PRESENT SETUP

"1. The Department should be preserved in its present general form at least for a few years more. The State has done a unique thing in associating programs of correction, juvenile correction and mental hygiene in one organizational structure. While it may be that the mental hygiene program derives little apparent benefit from this relation, it certainly suffers no hurt and the juvenile and adult correction programs have much potential assistance and support to gain from their relation to mental hygiene. The State, too, can benefit in what can become an effective way of avoiding duplication of certain resources of personnel and facilities.

"2. The General Assembly must decide in full realization of the factors involved whether it will continue to increase the support of the mental hygiene program so that it may approach ever more closely the most effective level of meeting the problems for which it is responsible, or whether it will declare the position reached is a plateau at which the State should rest content with the modest gains made. With full realization of the many increased and justifiable demands which will be made on the State's income, it is still the writer's opinion that to default now on the momentum gained will be to endanger the effect of what has already been spent.

STRESSES JUVENILE PROGRAM

"3. Realizing the relatively minor popular appeal such programs have, the writer cannot too strongly support the proposition that the correction and particularly the juvenile programs be given the same financial impetus which has been imparted to the mental hygiene program. Convicts for the most part do return to the general community and juveniles have a long course before them, for good or for ill. Rehabilitation of these individuals is as important to the health of the body politic as the successful treatment of the mentally ill and the maximum possible training for the retarded.

"4. The State must take serious and thoughtful steps to meet the growing problem of the aged dependent. Financial subsidy is not enough and will only grow unless provision is made to meet the senior citizens' needs—in rehabilitation, in housing, in protected employment and in recreation. The problems are poorly met by the present widely-used subterfuge of commitment to state mental institutions.

FINANCIAL NEEDS

"5. A review of the past few years' testimony will be a reminder that even $75,000,000 in bond issue construction funds will not be adequate to meet the current needs of the Department's case load. Magnificent as has been the acceleration toward provision of needed facilities, the requirements of many communities will be met only in part within this amount. It is not too early to begin thinking of construction support for the years beyond 1960.

"6. The Department's buildings are complex, specialized and many. For those anxious to increase both efficiency of result and speed of accomplishment in the Department's building program, serious consideration should be given either to the establishment of a competent planning unit in the Department or an augmentation of the staff of the Department of Public Works so that it may make long-term assignment of staff with specialized experience.

TENURE OF DIRECTOR

"7. Both the New Governor and the new General Assembly (remember this was written on October 15 last) should consider the tenure of the Director, his qualifications and his salary as well as his selection in their concern for the future of this Department."

Dr. Porterfield pointed out what he described as the "double penalty" imposed on the Department in the past: obsolescence of buildings and facilities and rapidly expanding population in Ohio.

He established as the turning point the creating of the Department as a separate function in 1953-54, and the necessary financial provision to initiate and operate a revitalized program.

A Choice To Make . . .

With Government Still Worming Its Way Between Physician and Patient. AMA President Re-Emphasizes Need for United Stand by the Profession

By DWIGHT H. MURRAY, M.D., President of the AMA

Delivered Before the House of Delegates of the American Medical Association in Seattle.

MR. SPEAKER and Members of the House of Delegates: Almost six months have elapsed since we last met to deliberate and act on medical affairs. The time has passed quickly, but not quietly.

The rumble of war and revolution has resounded in our ears. The din from political battles has been deafening.

All of us . . . sooner or later . . . learn that today's events do not just swirl around us, but involve each of us. As doctors we cannot get away from them by claiming that our only interest is in the sick, and that we cannot be bothered by political, social and economic problems. These matters demand attention from the doctors as well as the lawyer, the businessman, the newspaper editor, the labor leader and the worker.

If we are concerned about what happens on the international, national and local fronts—and we should be—then certainly we cannot afford to be disinterested in what happens in our own area of health and medical affairs. Yet there is apathy in our ranks.

NEED UNITED PROFESSION

Today there is a greater need for a united, forceful and informed profession than ever before. We have been caught in the throes of a social revolution which demanded something for nothing. Changes have been taking place all around us, and medicine has not escaped unscathed.

For example, in a few days Public Law 569, the bill providing medical care for military dependents, becomes effective throughout the land. Contracts already have been signed with the government by the majority of our state societies. No longer can any doctor claim that this law does not affect him. No longer can he say that government laws really are not changing the practice of medicine.

Public Law 880, better known to all of us as H. R. 7225, is another case in point. Medicine now is facing the problem of protecting the taxpaying public from abuses and of cooperating with the government to carry out the provisions of the law. The law is now on the books, and we must provide the leadership necessary to make it work as well as possible.

It was encouraging to hear Ezra Taft Benson, Secretary of Agriculture, say last week before the American Association of Land Grant Colleges and Universities:

"Sooner or later, the accumulation of power in a central government leads to a loss of freedom . . . Raids on the federal treasury can be all too readily accomplished by an organized few over the feeble protests of an apathetic majority. With more and more activity centered in the federal government, the relationship between the cost and the benefits of government programs becomes obscure. What follows is the voting of public money without having to accept direct local responsibility for higher taxes. . . .

"If the present shift of power from state to federal authority which started 25 years ago is allowed to continue, the states may be left hollow shells."

It was encouraging to hear such comments from a member of the President's Cabinet. I only wish that all members of the official family, and more important, every member of the United States Congress, felt the same way.

The expression of this philosophy, with which medicine so heartily agrees, sounds good, but putting it into practice is the thing we are really interested in.

Today the medical profession along with business and industry is caught between those who desire to promote sound government programs and those who desire even more intensely to perpetuate party power. Unfortunately, in recent years a benevolent federal government appears more attractive to the voting public than the preservation of individual freedoms. Medicine must do its utmost to reverse this trend.

MEDICAL FREEDOM ESSENTIAL

In my travels around the country as your representative the last 18 months, I **have seen little dissension or rancor** within our ranks. However, I must report that I have seen **too much complacency** over governmental encroachment into medical affairs. And I am deadly serious when I say to you that apathy by the few, or by the many, can be detrimental to all.

No nation can merely reap the benefits of freedom; it also must sow seeds of freedom.

In medicine the situation is the same. If an apathetic medical profession takes its freedom for granted, it will be the beginning of the end.

A strong, free profession must work for freedom so that it may live in freedom. And history tells us that once medicine loses its freedom, other fields of private endeavor are immediately in danger.

I do not wish to paint a dark or distorted picture of medicine's free status and its stature in America today. But I do believe words of caution and an appeal for vigilance are in order.

The road of apathy and disunity can only lead to disorder and perhaps disintegration, and we must sound a warning to all our colleagues who don't care, or who are pulling in the opposite direction. The road of alertness, action and unity is the proper road for all of us to be traveling together.

If I had just one wish for the coming year, it would be to command the time and talents of the 160,000 physicians in the American Medical Association. **I would set us all to the task of emphasizing and re-emphasizing the absolute necessity of patient and professional freedom.**

PATIENT'S RIGHT TO CHOOSE HIS DOCTOR

I believe it is of our prime responsibilities to prove to our patients that their right to choose their doctor is a most important one.

Free choice brings a bond of confidence between doctor and patient which no compulsory medical system can create. It means that the patient knows the physician will be interested in him as a person, not as just a serial number or the 2:45 appendicitis case.

For the doctor free choice means that the patient has selected him for his abilities, training, sincerity and personality. **When a patient comes into my office, I know he has made a choice.** And from that moment there begins a physician-patient relationship of the highest order. To me the patient is someone special, and I in turn hope that I am someone special to him.

Once the patient has made his choice, the physician automatically assumes an unqualified responsibility to the patient. No system of medical care that uses a third party to bring doctor and patient together can match our kind of cooperative performance for the treatment of illness, the cure of disease and the betterment of the patient's health.

Freedom to select a doctor is part of everyone's great freedom to choose—to choose what he wears and eats; where he works and worships, and how he votes. Take away any part of this freedom and great damage is done to our democratic system.

FREE CONDUCT IN MEDICAL TREATMENT

Another freedom closely tied to freedom of choice is freedom in the conduct of medical treatment.

At the recent meeting of the World Medical Association in Havana, Cuba, Dr. Rolf Schloegell of Germany made a stirring defense of free conduct of medical treatment. He told us that the medical profession believes the attending physician alone is competent to decide what measures he deems necessary and will apply in order to bring about the desired improvement. He warned too of the danger of excessive restriction on the freedom of the patient and the attending doctor.

Yet the trend toward extending social security in the medical care field has been steady and has accelerated since the end of World War II.

The dangers of shifting responsibilities for medical care from the patient and doctor to the government are obvious. The caliber of medical care cannot be as high when both patient and doctor are dependent upon government. Initiative succumbs to dictation, and self-reliance is replaced by the crutch of government.

We do not deny that there is an area of legitimate concern by the government for the health and welfare of the people. But each year government seems to extend that area. We get some idea of this expansion from the new federal medical budget.

This year, according to our Washington Office, **the average family will be paying $54.61 for the U. S. Government's health and medical activities.** And the total expenditures this year amount to 2½ billion dollars—290 millions more than last year. Even in an overall federal budget of 61 billion dollars, the total health cost of 2½ billions is not insignificant. It is a billion dollars more than the cost of running the Commerce Department, half a billion more than the Agriculture Department and six times more than the Interior Department's budget.

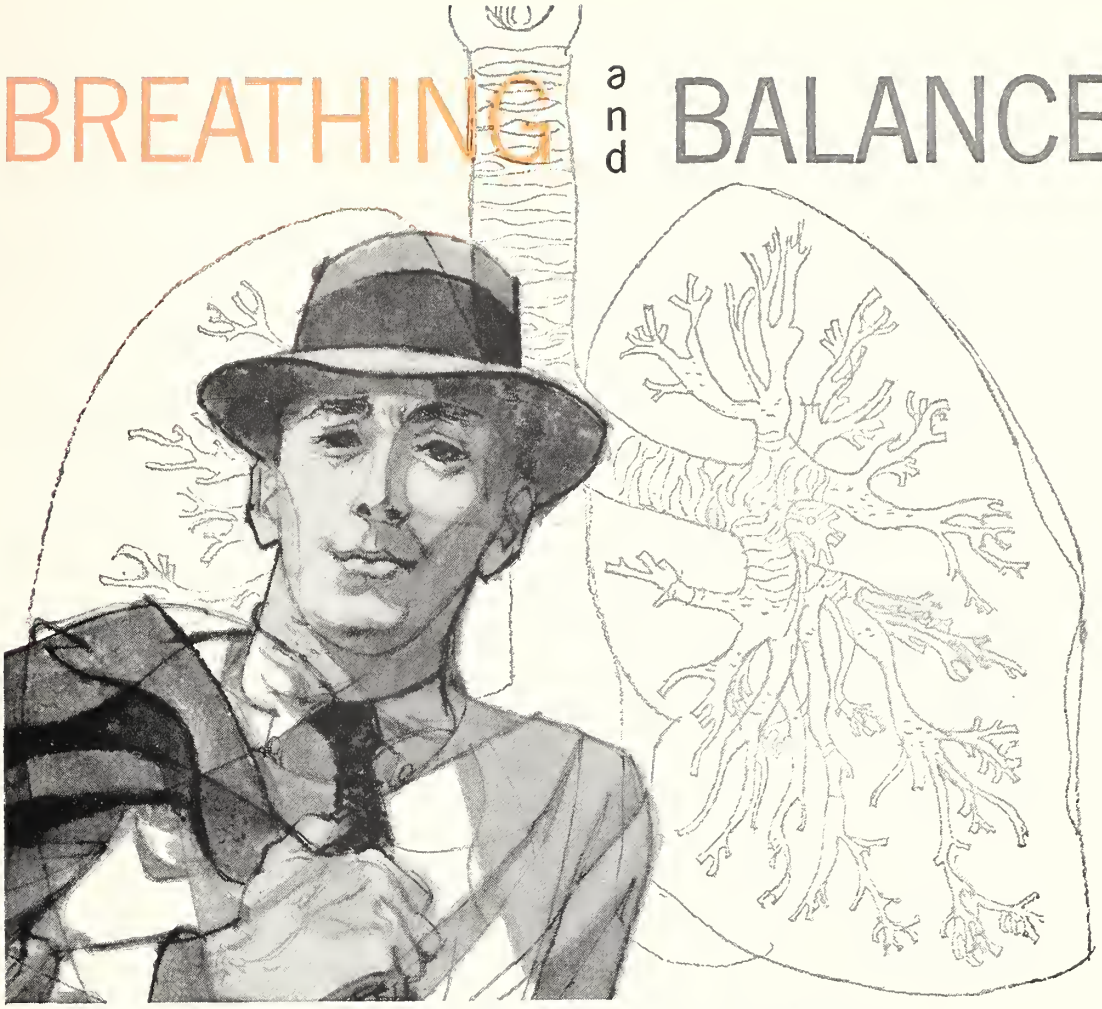
Many expenditures obviously are necessary to keep up our unsurpassed public health standards, and research may pay rich dividends in scientific discoveries. But there is no doubt that much money is being spent on medical activities that should not involve government participation.

The trend is to spend more and more government money on health and medical matters because it is good politics. Apparently many Americans still want to see government in the role of a big brother, dishing out so-called gifts and bargains under the guise of benevolent economic planning.

I believe it is our duty, as it is everyone else's, to combat the attitude of "what's in it for me?" and to promote the long-honored creed of "what's best for all Americans and our free society." I think that a nation can drift into state medicine inch by inch just as surely as if the scheme were foisted upon a people overnight. The "drift" method may take longer but the result will be the same.

So it is time all of us sounded the alarm against soft and superficial security and against the invasion of personal responsibility. It is time we stood up together for militant freedom

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*Schwartz, E.: New York J. Med. 56:570, 1956.

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BELGIAN DOCTORS TURN BACK GOVERNMENT

There is no better example of what a unified medical profession can do than in the story of the recent fight of the Belgian doctors against the government's proposals for a state service of medicine.

Without consulting the medical profession the Belgian government proceeded to draft rules and regulations of health to be incorporated in the nation's social security legislation. Under the proposals doctors were to sign an agreement to abide by the present rules and any later regulations. For the patient there would be the usual red tape in getting medical care.

When the Belgian doctors learned of the scheme, they met in conference with the government. They told the government what they wanted and what they would not accept. The government agreed.

For several months everything was quiet. Then the Belgian doctors suddenly read about the new health bill that the government was sending to Parliament. It was quite contrary to the earlier agreement worked out by the profession and the government. But the bill was passed quickly.

The Belgian medical profession protested and said it would not be placed under the Ministry of Labor. Instead the doctors proposed to set up their own plan of medical assistance.

Before long, the government saw that the medical profession meant business and that the doctor's plan was an attractive one. So it declared that its own bill was not in force and could not be in force without the consent of the medical profession.

To me this fight against legislative intervention in medical care is excellent **evidence that the profession can defend itself if it unites to defend the basic principles of freedom and if it offers constructive proposals.** By using the Belgian national motto, "in union there is strength," the medical profession showed doctors everywhere that dangerous government plans can be turned aside by the strong.

I also read recently in the *Journal of the World Medical Association* of the fight of the medical profession of Malta against a British government scheme to introduce a full-time salaried medical service, without the right of private practice, on an island dependency of Malta. Here again the doctors reacted with unity and strength, and successfully thwarted the government's plan.

There is a lesson in these stories from Belgium and Malta. They prove that a unified profession has a great political power for good—the good of the patient, the doctors and the nation.

CONFIDENCE OF PATIENTS, UNDERSTANDING OF LEGISLATORS NEEDED

While we are developing unity within our own ranks, I believe it is equally important to continue to build up the confidence and respect of our patients, and to make our legislators aware of the necessity for freedom in medical practice.

Let us never reduce the quality of service we render to our patients, and never lose the personal touch in medicine. Where there is any opportunity to improve upon our medical care, let us seize it and show our abilities to do an outstanding job. Satisfied patient-customers will give us deserving support when we need it.

We also should realize that the destiny of medicine can be determined to a large degree in the halls of Congress. If this be true, then it is even more important that we take an even greater interest in those who elect the Congressmen. **Sympathetic understanding of our position by federal legislators through the voting public will be an insurmountable deterrent to the forces supporting state medicine.**

The day has come, gentlemen, when we can no longer look upon medical economics and social changes merely as issues to be considered during our limited leisure hours. Our interest in them cannot be superficial or intermittent.

We now must pay daily attention to these matters. Medical socio-economic affairs can no longer be just incidental with us. They must be a vital part of our life and of our profession.

Each of us, I believe, should dedicate himself to the words included in the oath of office taken by Presidents of the AMA.

"I shall champion the cause of freedom in medical practice and freedom for all my fellow Americans."

As doctors, representatives to the AMA and as spokesmen for the AMA, let's remember these words and live by them. And to alter a phrase of President Lincoln's only slightly: Let's make common cause to keep the good ship of medical freedom on this voyage, or nobody will have a chance to pilot her on another voyage.

Medical Education Week

Doctors of Ohio will be interested to learn of the achievements of U. S. Medical Schools when they are listed during Medical Education Week, April 21-27.

Sponsors of the observance, whose representatives met recently to develop plans for national and local participation, are the Association of American Medical Colleges, the AMA, Student AMA, Woman's Auxiliary to the AMA, American Medical Education Foundation and the National Fund for Medical Education.

Each of the sponsoring organizations is preparing suggested activity formats for state and county medical societies, medical schools and allied groups. These materials will be distributed in the near future.

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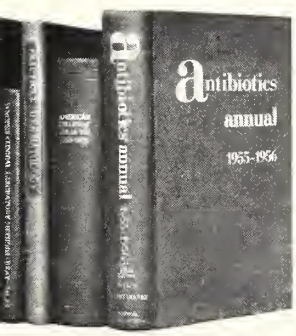
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1. Romansky, M.J., et al., Antibiotics Annual 1955-1956, p. 48.
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M., A.M.A. Archives of Internal Medicine, 1954, p. 556.

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Pre-School Health . . .

Expanding on Its Successful "Summer Roundup Program" the PTA Now Advocates a Program of Continuous Health Supervision of Children

THIS YEAR, as in the past, physicians and medical societies will receive requests from schools and community organizations for assistance in planning and conducting summer health appraisals of children who will enter school in the fall. The facts presented below have a bearing on the subject and are printed for the information of those concerned.

The National Congress of Parents and Teachers inaugurated the "Summer Roundup Program" in 1925. It advocated a single health appraisal upon entrance to school.

During recent years many medical men have suggested a broader program encouraging continuous health supervision of children from birth through their school years.

The National Congress of Parents and Teachers requested the advice of medical and allied professions on this matter, and last year invited 20 organizations, including the AMA, to a conference to discuss the program.

The conclusions of the conference were later presented to the Board of Managers of the National Congress and were approved.

Dr. Thomas E. Shaffer, Columbus, Chairman of the Committee on School Health of the Ohio State Medical Association, participated in the conference and has submitted to the *Ohio State Medical Journal* for publication, the new national policy of the PTA.

The text is as follows:

NATIONAL PTA POLICY

I. That the National Congress of Parents and Teachers adopt a policy supporting and encouraging a program of continuous health supervision of children from birth through their school experience, rather than only a program of single appraisal on school entrance.

II. That the National Congress of Parents and Teachers recommend to its local units a promotional and educational program that will tend to bring children and their parents into effective contact with the health resources of the community.

Wherever possible, these should be the physician and dentist who normally serve that child or family, whether they be working in private practice or in a community health service.

A program of continuous health supervision has been recommended repeatedly by medical, dental, school, and public health personnel. The role of the parent-teacher association will be to acquaint parents with the means of effectively utilizing the resources available to meet the health needs of children, beginning at birth and continuing through the school years. The parent-teacher association also should work with the professions and agencies of the community in planning and carrying out such a program.

A program of the character contemplated has been outlined by a committee of the American Public Health Association, in a report entitled *Health Supervision of Young Children*, the essential elements of which are as follows:

A. **Periodic health appraisal of the child**, preferably by his own physician and dentist, to give long-term continuity, including—

1. Well-recorded medical, dental, and developmental history.
2. Physical examination to evaluate physical, mental, and emotional development and adjustment, and to discover deviations.

B. **Immunizations.**

C. **Consultation with parents:**

1. To advise about feeding, nutritional needs, immunizations, recommended corrective procedures, accident prevention, and health protection.
2. To interpret what a child is like—his normal growth and his particular stage of development.
3. To assist in the management and prevention of behavior and personality problems.
4. To plan required treatment and to refer parents to appropriate services when necessary.
5. To help parents become more capable and self-confident, and to build good parent-child relations and promote family well-being.

III. That the National Congress of Parents and Teachers recommend to its local units that the following activities, among others, be accepted as their role in the child health program:

A. **Educational**

1. Acquaint residents of local communities with existing health facilities and explain how to use them effectively.
2. Interest school personnel in the importance of preschool health as preparation for school attendance.
3. Aid in bringing about realization of the importance of the public health unit, especially the nurse, in health promotion.

B. **Promotional**

1. Make surveys to ascertain what children are not now receiving continuous health supervision.
2. Cooperate with other agencies in promot-

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ing the planned program of periodic health appraisal most suitable to any given community at the time of study.

3. Assist in developing school health councils or subcouncils on school health under already existing community councils.

4. Irrespective of what special medical examinations a child may need, recommend that primary general examination be made by the family physician or pediatrician.

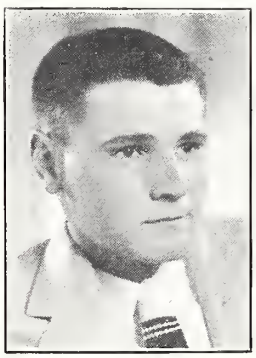
5. Aid in development of cumulative child health records and their use by parents, physicians, dentists, and schools.

6. Promote research in child health programs as cooperative activities involving medicine, education, and public health.

Fulton County Youth Wins First OSMA Award in 4-H Club Health Improvement Contest

Winner of the Ohio State Medical Association award in the Annual 4-H Club State-wide Health Improvement Contest is Richard Mull, age 18, of Route 4, Wauseon, Fulton County. This recognition was in the form of an all-expense trip to the National 4-H Club Congress at Chicago in November.

The son of Mr. and Mrs. Corwin Mull, Richard is a member of the Clinton Doodle Bugs 4-H Club and has completed steer feeding projects and projects in potatoes and electricity. He has 9 years of 4-H Club work and feels that the "Health H" is really important in his community.



RICHARD MULL

In connection with winning the state-wide contest he helped promote health through participation in county camps, water testing drives, health demonstrations in the community, and took part in the promotion of good mental health.

He is a member of the Fulton County 4-H Junior Leadership Club; has been awarded the State Farmer Degree of the Future Farmers of America and is active in Church and Sunday School affairs.

Rehabilitation Institute

The Conference of Rehabilitation Centers, Inc., has scheduled an Institute on Rehabilitation Center Planning in Chicago February 1 to March 1. Registrations are being accepted at the Conference's offices, 5 Franklin Avenue, Saranac Lake, New York.

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[1] Biskind, L. H., and Biskind, J. I.: MISSOURI MEDICINE: 53:843-848, (Oct.) 1956.

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A two months full time course. In Obstetrics: lectures; prenatal clinics; attending normal and operative deliveries; detailed instruction in operative obstetrics (manikin). X-ray diagnosis in obstetrics and gynecology. Care of the newborn. In Gynecology: lectures; touch clinics; witnessing operations; examination of patients pre-operatively; follow-up in wards post-operatively. Obstetrical and gynecological pathology. Culdoscopy. Studies in Sterility. Anesthesiology. Attendance at conferences in obstetrics and gynecology. Operative gynecology on the cadaver.

DERMATOLOGY AND SYPHILOLOGY

A three year course fulfilling all the requirements of the American Board of Dermatology and Syphilology. Attendance at departmental and general conferences.

FOR INFORMATION ABOUT THESE AND OTHER COURSES ADDRESS—
THE DEAN, 345 West 50th Street, New York 19, N. Y.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems: Suggestions Regarding Organized Activities

NEW PATIENT INFORMATION CARD HELPS EFFICIENCY

Physicians in Chemung County, New York, have adopted a small card form on which to enter for business office files nonmedical information on new patients.

This is an efficient system of obtaining such information. The card is handed to the patient to fill out, whether it is an office visit or a house call. It provides a direct, accurate and polite means of getting information, such as correct spelling of name, address, phone, employer, insurance company and name of relative responsible for the patient.

If you desire to try this idea to help establish from the start a good doctor-patient relationship, it is suggested you hand the patient a copy of "To All My Patients"—the excellent AMA pamphlet—along with the information card.

MEDICAL SOCIETY AS LEADER OF COMMUNITY'S PROGRESS

The Summit County Rehabilitation Center, organized three years ago on recommendation of the Summit County Medical Society, has achieved recognition as an outstanding success.

Its job is to rebuild bodies, and to some extent minds, damaged by illness and accident. It employs the latest in physical and occupational therapy, vocational and psychological counseling. The center's growth is attested by the fact that it served 532 patients its first year, 662 its second year and nearly 1,000 in 1956.

In commenting on the success of the center, operated as a United Fund agency, Dr. Albert F. Dorner, SCMS president, stated, "We are very happy with the results that have been shown. We are hopeful that (the center's) scope will increase and that it can serve more members of the community."

The success of the center is a good example of how local medical societies can contribute to community growth and progress by initiating and supporting such projects. The rewards are well worth the effort.

INTERNAL REVENUE RULING APPEARS TO SPLIT HAIRS

This medical expense income tax deduction dispute could not be passed without comment:

The government held that installation of an elevator in a home by taxpayer for his wife, who had osteo-arthritis, was a non-deductible capital improvement and only a convenience, while installation of such an elevator for a person with heart trouble or other ailments that stairs would aggravate would be a deductible medical expense.

The court reversed the ruling and held the deduction legal because the elevator kept the osteo-arthritic condition from becoming worse. Deduction for a paralytic, on the other hand, would not have been allowed because the elevator would serve only as a transportation means.

It would appear that such reasoning involves some rather fine hair-splitting.

PHYSICIANS CAN PREVENT IMPROPER USE OF DRUGS

Ohio physicians can help to guard against improper use of unrestricted drugs and barbiturates by observing and reporting any harmful side effects of such drugs and barbiturates.

Current Federal legislation requires a prescription for any drug which is potentially unsafe when used without medical supervision. By reporting observations of harmful effects of drugs, physicians can help to prevent their improper use.

A manufacturer or any interested person who believes prescription restriction for a particular drug or barbiturate is no longer necessary, and has supportive evidence, may petition the Food and Drug Administration to have the item removed from the restricted list.

By reporting harmful side effects, a physician is helping to keep a potentially harmful drug on the restricted list—where it belongs.

MEDICAL MEN CAN HELP REDUCE HIGHWAY DEATHS

In the United States, a person is killed every 14 minutes and one injured every 25 seconds on our highways. Ohio is not immune to these accidents but Ohio physicians can do something about them.

The role of the physician in traffic accident prevention should be strengthened. Medical men can contribute much in this field in various ways.

First, the doctor who prescribes drugs which have a sedative effect should warn his patient not to drive while under the influence of those drugs. Second, the physician should point out to the patient that conditions such as severe pain, itching or nervousness can detract the driver's attention from the road just long enough to be a fatal detraction—even if it is only a matter of a few seconds.

Third, physicians can help prevent accidents through more active interest in medical standards

of driver licensing and maintenance of driver fitness.

Local medical societies, through promotion of sound traffic safety programs, safety councils and driver education, not only are making a significant contribution to their community but are advancing into a field of almost unlimited public relations opportunities. What is your society doing in this field?

MAIN REASONS FOR SUITS OF MALPRACTICE LISTED

With more and more attention being given to malpractice litigation, Ohio doctors should be interested in a list of the main causes of threats and suits and should make every possible effort to keep these causes out of their practice.

Ten major causes of malpractice suits have been listed as a result of studies made by an American College of Surgeons insurance underwriter, as follows:

1. Hasty or inconsiderate treatment resulting in poor patient-doctor relationship.
2. Criticism by one physician or surgeon of another's methods or results.
3. Failure to call in well qualified consultants promptly when surgeon or patient is dissatisfied with progress.
4. Permitting patient to become overoptimistic about outcome of treatment.
5. Failure to maintain complete records of history, findings, treatment and operation.
6. Failure to obtain proper written consent to perform operations.
7. Failure to instruct and supervise office or hospital assistants properly as to their responsibilities and conduct.
8. Failure to see that office and hospital equipment and supplies are adequate and maintained in perfect condition.
9. Patient's dissatisfaction with amount of bill, and surgeon's failure to discuss finances in advance of operation.
10. Failure to notify insurer or attorney of incidents that might result in malpractice suits.

BRITAIN'S 'DREAM' MEDICINE IS MORE LIKE A NIGHTMARE

"For three months I had to send my ambulance drivers joy riding around the country to use up gasoline. If I hadn't, the ambulance accounts would have shown a saving on the year and I would have had my allocation slashed."

That comment was made by a British hospital matron to two American observers of Britain's socialized health service. Some other conditions reported by the observers were:

No new hospitals have been constructed since the state medicine was installed in 1948. Yet there are long lines of people waiting for treatment.

If an agency spends one penny more than its appropriation, a fabulous investigation as to why it was spent is made, and costs hundreds of pounds.

The two American observers, both of whom are writers, concluded:

State medicine puts doctors "in the same bracket as any other kind of civil servant. They are assured a living, but where is the incentive to reach for the stars? Not just the monetary stars but the kick they might get out of discovering a new cure via their personal, private research. Today there isn't any private research (in Britain). It's all handled through state laboratories."

In our opinion, the British situation adds further support to the fact that proper medical care cannot be provided individuals on an assembly line basis.

Hoxsey Cancer Treatment Declared A Fraud by Another Court

For the second time, a Federal court has determined that the Hoxsey medicines for internal cancer are worthless. On November 15, 1956, after a six-week trial in the Federal court at Pittsburgh, the jury returned a v e r d i c t that these medicines, in pill form, were illegally offered as an effective treatment for cancer. On November 16, U. S. District Judge John L. Miller signed an order of condemnation stating that the pills were misbranded as charged by the Government and ordering their destruction.

The foregoing statement was issued by George P. Larrick, commissioner of food and drugs for the U. S. Department of Health, Education and Welfare. This is the second public warning issued by Mr. Larrick within a matter of months on this subject. A previous warning, based on findings of the U. S. Court of Appeals for the Fifth District, was published in the May, 1956, issue of *The Journal*, page 522. Mr. Larrick's statement in part continues:

"The public should know, however, that this action does not end the menace of this fake treatment. It merely means that half a million of the Hoxsey pills, which were seized shortly after the opening of a second Hoxsey Clinic at Portage, Pa., will now be destroyed. An injunction is being sought to stop further interstate shipment of the pills. We intend to use every legal means within our power to protect consumers from being victimized by this worthless treatment. . . .

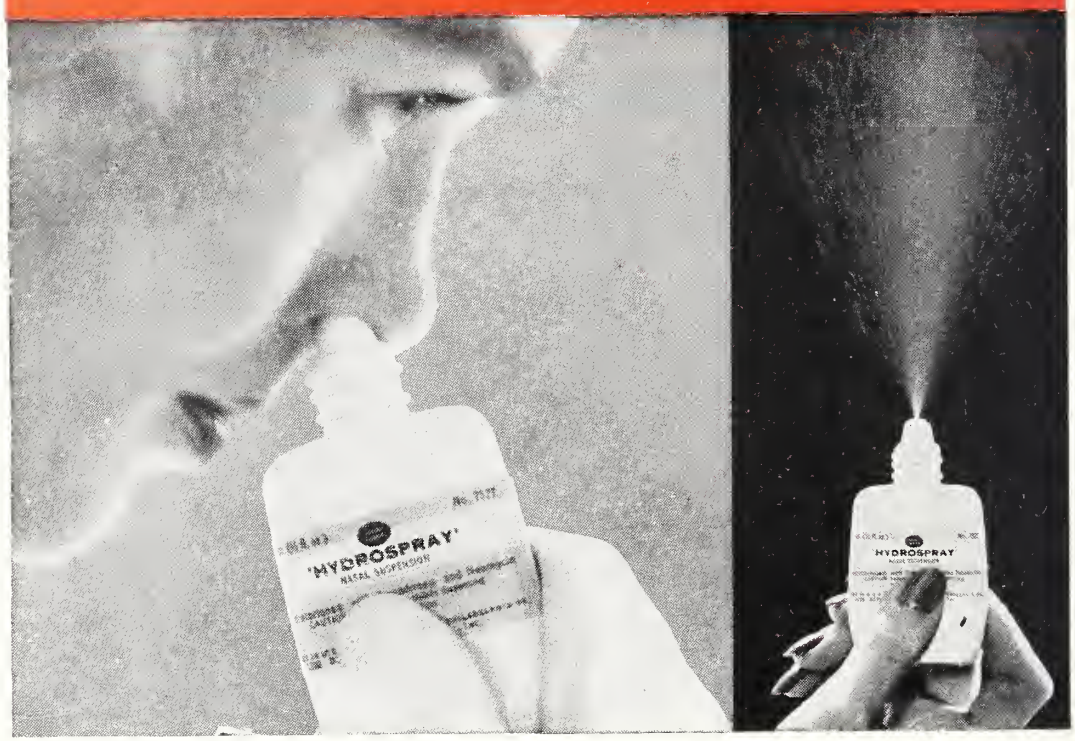
"Harry M. Hoxsey has continued to promote his worthless cure for more than 30 years, notwithstanding numerous local and state court actions. Proceedings under the Federal Food, Drug, and Cosmetic Act did not appear possible until a 1948 decision of the Supreme Court interpreting the word "accompanying" in the definition of labeling under the Act. An injunction suit was filed in 1950 and a decree finally issued by the Federal court at Dallas in 1953. . . ."

'Hydrospray' NASAL SUSPENSION

(HYDROCORTONE® WITH PROPADRINE® AND NEOMYCIN)

Anti-inflammatory—
Decongestant—Antibacterial

MAJOR ADVANTAGES: New synergistic anti-inflammatory, decongestant and antibacterial formula. High steroid content assures effective response.



Topically applied hydrocortisone[1] in therapeutic concentrations has been shown to afford a significant degree of subjective and objective improvement in a high percentage of patients suffering from various types of rhinitis. HYDROSPRAY provides HYDROCORTONE in a concentration of 0.1% plus a safe but potent decongestant, PROPADRINE, and a wide-spectrum antibiotic, Neomycin, with low sensitization potential. This combination provides a three-fold attack on the physiologic and pathologic manifestations of nasal allergies which results in a degree of relief that is often greater and achieved faster than when any one of these agents is employed alone.

INDICATIONS: Acute and chronic rhinitis, vasomotor rhinitis, perennial rhinitis and polyposis.

SUPPLIED: In squeezable plastic spray bottles containing 15 cc. HYDROSPRAY, each cc. supplying 1 mg. of HYDROCORTONE, 15 mg. of PROPADRINE Hydrochloride and 5 mg. of Neomycin Sulfate (equivalent to 8.5 mg. of neomycin base).

MSD

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PHILADELPHIA 1, PA.

REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* **60**:431, Oct. 1954.

Iowa Doctor-Hospital Dispute . . .

Believe Agreement Reached in Legal Battle Through Adoption Of Joint Declaration of Principles by Officials of Two Groups

THE Iowa doctor-hospital dispute appears to be settled through a compromise agreement worked out between the Iowa State Medical Society and the Iowa Hospital Association and ratified by officials of both organizations.

Under terms of the agreement, all work of radiology and pathology departments is considered medical service, and bills for such services must be submitted in the doctor's name.

The agreement, reached by a joint committee from the two associations provides that there cannot be an employer-employee relationship between a hospital and a physician. Also, it provides that "a contract may be oral or written and shall provide for compensation as agreed to by the parties involved, but any compensation arrangement must conform to the principles contained in the (committee's) Joint Declaration."

Another provision is that a hospital may bill for pathology and radiology services and collect them on behalf of the doctors, but the services shall be billed as medical services in the name of the physician. It states the hospital may retain from the collections, a sum agreed on jointly by the doctor and the hospital. It also provides the patient should sign a statement acknowledging such arrangements when he enters the hospital.

PROVISIONS OF AGREEMENT

Main provisions of the agreement are as follows:

"1. The ownership and maintenance of the laboratory and x-ray facilities and the operation of same under this joint declaration is a proper function of a hospital.

"2. Pathology and radiology services performed in hospitals are the product of the joint contribution of hospitals, doctors and technicians but these services constitute medical services which must be performed by or under the direction and supervision of a doctor, and no hospital shall have the right, directly or indirectly, to direct, control or interfere with the professional medical acts and duties of the doctor in charge of the pathology or radiology facilities or of the technicians under his supervision.

"3. Each hospital should arrange for such services and for the direction and supervision of its pathology or radiology department by entering into either an oral or written agreement with a doctor who is a member of or acceptable to the hospital medical staff. Such doctor may or may not be a specialist. The laboratory may be supervised and directed by a qualified member of the staff and specific services may be referred to a specialist, or the specialist may also direct and supervise the laboratory as may be desired. Any contract so entered into shall be in accordance with the principles stated herein.

"4. Technicians and other personnel (not including doctors) in pathology or radiology departments, shall (unless the department is leased or unless the hospital and doctor mutually agree otherwise) be employees of the hospital, subject to the rules and regulations of the hospital applicable to employees generally, but under the direction and supervision of the doctor in charge of the Department as set forth elsewhere in this Declaration.

"5. The doctors and hospital shall mutually agree upon the employment of any technicians necessary for the proper operation of said Department and no technicians shall be dismissed from said employment without the mutual consent of the parties, provided, however, that in the event the hospital and doctor are unable to mutually agree upon the hiring or discharge or disciplining of any employee of said Departments, the matter shall be promptly submitted to the joint conference committee.

DOCTOR NOT AN EMPLOYEE

"6. The contract between the hospital and doctor in charge of the laboratory or x-ray facilities may contain any provision for compensation of each upon which they mutually agree, provided, however, that no contract shall be entered into which in any way creates the relationship of employer and employee between the hospital and the doctor, and a percentage arrangement is not and shall not be construed to be unprofessional conduct upon the part of the physician or in violation of the statutes of the State of Iowa upon the part of the hospitals.

"7. The hospital admission agreement signed by the patient or his legal representative shall contain the following statement:

" 'Pathology and radiology services are medical services performed by or supervised by physicians, and the personnel and facilities are furnished by the hospital for said services. Charges for such services are collected, however, by the hospital on behalf of said doctors pursuant to an agreement between said physicians and the hospital, and from said charges I consent that an agreed sum will be retained by the hospital in accordance with an existing agreement between the doctor and the hospital.'

"8. The hospital bill shall properly include the charges for pathology and radiology services

as long as the name of the doctor is stated and it fairly appears that the charge is for medical services.

"The said hospital bill shall also contain a statement substantially in the following form:

" 'The pathology and radiology charges are for medical services rendered by or under the direction of the doctor listed above and are collected by the hospital on behalf of the doctor, from which charges an agreed sum will be retained by the hospital in accordance with an existing agreement to which retention you consented at the time of your admission to the hospital.'

"9. All fees to be charged by the physician for pathology and radiology services shall be mutually agreed upon by the hospital and the doctor. In the event dispute shall arise between the parties the matter shall be submitted for judgment to the Joint Conference Committee.

A MEDICAL SERVICE

"10. Fees for radiology and pathology services must be paid for as medical and not hospital services. In all cases this requires payment by 'Blue Shield' (Iowa Medical Service) and not by 'Blue Cross' (Hospital Service of Iowa)."

The joint committee, consisting of three Iowa State Medical Association representatives and three hospital trustees, is expected to draw up and present to the two associations a legislative program designed to eliminate any reasonable doubts about the legality of the agreement.

Expected to be dismissed upon implementation of the joint agreement is an appeal to the Iowa Supreme Court of a district court ruling that salary arrangements with medical specialists, other than lease, violated the Iowa Medical Practice Act.

The lower court held that such arrangements constitute the practice of corporate medicine on the part of a hospital and fee splitting on the part of a physician.

Standard Nomenclature Of Diseases, Operations

Short courses on use of the *Standard Nomenclature of Diseases and Operations* planned by the AMA will be of interest to physicians in Ohio.

The AMA plans to conduct two—and possibly three—such courses during 1957, with the first to be held March 11-13 in Roanoke, Va., and the second August 5-7 in San Francisco. A third session probably will be scheduled in the fall.

The three-day meetings are conducted by the AMA as a special service to medical record librarians and others using the *Nomenclature* in the hospital, doctor's office or medical clinic.

Anyone employed as a clinic clerk, doctor's secretary or receptionist, nurse or physician may attend. Tuition is free. Applications should be sent to AMA Headquarters, Chicago, Attention Mrs. Hayden.

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Bureau of Workmen's Compensation . . .

Medical Services to Workers Amounted to More Than $7 Million During Year; 61 Per Cent of Total Claims Were in the "Medical Only" Class

THE Bureau of Workmen's Compensation, or Industrial Commission of Ohio as it formerly was known, during 1955 paid out $7,473,546.61 for medical services to injured Ohio workers, according to information provided by the Actuarial Section of the Bureau. That amount excluded a small sum for dental services.

Other 1955 expenditures, exclusive of compensation payments, included the following: $8,441,211.63 for hospital care and nursing; $301,701.94 for funeral expenses, and $395,264.91 for miscellaneous costs. With disbursements for medical expenses added, the total is $16,611,725.09.

These amounts include payments covering treatment of injured private and public employees, as well as similar costs for occupational disease claims.

Comparative figures for 1954 were as follows: $7,589,116.23 for medical service; $8,159,133.84 for hospital care and nursing; $328,415.26 for funeral expenses, and $475,817.70 for miscellaneous; a total of $16,554,055.84.

The number of claims filed during 1955 was 335,468 or 4.9 per cent more than in 1954.

"Medical-only" claims, involving payment for physicians' services, but with no compensation for the claimant for loss of time, numbered 204,683 for 1955, or 61 per cent of all claims filed. The average amount paid out for "medical-only" claims increased from $15.71 to $17.03 in 1955.

Table 1 is a financial statement of the Ohio Insurance Fund.

Table 2 gives 1955 awards that have been made for active claims according to the year of injury and having injury dates which in some cases reach back to the beginning of the fund (1912).

TABLE 1

OHIO STATE INSURANCE FUND

(Workmen's Compensation)

STATEMENT OF FINANCIAL CONDITION

As of December 31, 1955

ASSETS

	Private	Public	P.W.R.E.	Safety & Hygiene	Total
Cash	$ 231,684.19	$ 9,503 48	$ 1.126.70	$ 2.620.81	$ 244.935.18
Bonds	185,434,915 03	7,607,001.43	895,978.27	2,099,512.77	196,037.407.50
Premium in Course of Collection	48,961,457 99	6,233,597.81	25.864.04		55,220,919.84
Accrued Interest	891,987.56	36 588.56	4,337.82	10,090.14	943,004.08
Total Assets	$235,520,044.77	$13,886,691.28	$927,306.83	$2,112,223.72	$252,446,266.60

LIABILITIES

Reserves for Medical and Compensation	$191,669.182.10	$13,861.965.26	$103,707.25		$205,634,854.61
Administrative Cost Assessment	971,670.30	20,302 57			991,932.87
Advance Premium Deposits	32,061,737.32				32,061,737.32
Fund				2,112,223.72	2,112,223.72
Reserve for Contingencies and Surplus	10,817,495 05	4,423.45	823,599 58		11.645,518.08
Total Liabilities	$235.520.044.77	$13.886.691.28	$927,306 83	$2,112,223.72	$252,446,266.60

TABLE 2—PRIVATE FUND

Medical, Hospital, Etc., Awards Distributed to Year of Injury Occurrence

(Accident and Occupational Disease Combined)

Year of Accident or Disease	Awarded	1955 Per Cent	1954 Per Cent
1955	$ 6 513.981	43	44
1954	3,824,159	25	29
1953	1,296.810	9	8
1952	801.968	5	5
1951	538.476	3	3
1950	410.132	3	2
1949	292.677	2	2
1948	180,177	1	1
1947	156,798	1	1
1946	164 586	1	—
1912-1945	1,020,770	7	5
	$15,200,533	100	100



...IN URINARY COMPLAINTS

✳ *Sterilizes urine in 1 to 3 days*

✳ *Relieves burning in minutes*

✳ *Effective in 93-98% of cases*

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The original Azo-Sulfa Formula*
Antibacterial • Analgesic

LOCALIZED MUCOSAL ANALGESIA

Phenylazo-diamino-pyridine HCl—acts solely on the urogenital mucosa; provides prompt relief from burning, pain and frequency.

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Sulfacetamide—eliminates mixed infections rapidly because of its unusual solubility in acid urine common to bacterial invasion of the urinary tract. No renal damage, concretions or anuria.

...and when Spasmolysis is essential

sulfid B-A

Antibacterial • Analgesic • Antispasmodic

—the dual activity of SULFID with the well-known antispasmodic effect of natural belladonna alkaloids.

FORMULAE:

SULFID—Each coated tablet contains: Phenylazo-diamino-pyridine HCl, 50 mg. and Sulfacetamide, 250 mg., in bottles of 100 tablets.

SULFID B-A—Each coated tablet contains the SULFID formula with natural belladonna alkaloids, 0.065 mg., in bottles of 100 tablets.

COLUMBUS PHARMACAL COMPANY—Columbus 16, Ohio

*Introduced—July, 1954

In Memoriam . . .

John F. Conner, M. D., Sidney; Eclectic Medical College, Cincinnati, 1915; aged 62; died November 17; member of the Ohio State Medical Association and the American Medical Association. Dr. Conner had been a practicing physician in Sidney since 1919. He was active in community affairs, being a 32nd degree Mason and a member of the Elks Lodge. Surviving are his widow and two daughters.

David Clements Frick, M. D., Toledo; St. Louis University School of Medicine, 1933; aged 49; died November 6; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A life resident of Toledo, Dr. Frick did all of his practice there with the exception of time served in the Air Force Medical Corps during World War II, during which he attained the rank of lieutenant colonel. He was particularly interested in diabetic children and helped organize summer camps for them. Affiliations included memberships in several Masonic bodies, the Toledo Yacht Club, the Methodist Church and the Kiwanis Club. Survivors include his widow, a daughter and his mother.

Jesse John Heaton, M. D., Tiffin; Ohio Medical University, Columbus, 1905; aged 74; died November 9; member of the Ohio State Medical Association through 1952. Dr. Heaton practiced in McCutchenville for many years. About 20 years ago he moved to Tiffin where he became health commissioner and also engaged in private practice. A veteran of World War I, during which he served with the Medical Corps, he was a 32nd degree Mason, and a member of the Methodist Church. His widow survives.

Charles E. Holzer, Sr., M. D., Gallipolis; Ohio State University College of Medicine, 1909; aged 69; died November 1; member of the Ohio State Medical Association and the American Medical Association, and Fellow of the American College of Surgeons. After completing his internship, Dr. Holzer went to Gallipolis as medical officer for the Gallipolis State Institute. Almost immediately he saw the need for a hospital in the area and set up a temporary one in a residence. Later he built a permanent hospital and added to it as the need increased. The institution was given as a gift to the community in 1949. The local newspaper said of him, "He was vitally concerned with every phase of community and area life. The area is covered with his landmarks." He was a founder and early president of Friends of the Land and took a leading part in the Ohio and Mississippi River Improvement Association. His work in conservation was recognized when he was presented the Hugh Bennett award in 1951 and later granted a state award by Governor Frank J. Lausche. He was awarded an honorary degree of doctor of laws from Ohio State and an honorary doctor of science degree from Rio Grande College, both of which institutions he served as trustee. He was a trustee of the Methodist Church, a member of several Masonic bodies, member of the Elks Lodge, and active in numerous other organizations. Survivors include his widow, three daughters and two sons. One son, Dr. Charles E. Holzer, Jr., succeeded his father as chief of staff of the Holzer Hospital.

John E. Hunter, M. D., Dayton; Western Reserve University School of Medicine, 1889; aged 87; died November 14. A practicing physician for 63 years, mostly in Lexington, Ky., Dr. Hunter retired in 1952 and moved to Dayton to live with a son. Three sons, a daughter, a sister and a brother survive.

Alvin E. King, M. D., Mt. Cory; Eclectic Medical College, Cincinnati, 1912; aged 75; died November 29; member of the Ohio State Medical Association through 1951. A native of Hancock County, Dr. King practiced for 41 years in that vicinity. Active in many community activities, he served on the Hancock County Board of Health and the Mt. Cory School Board. He is survived by his widow, a daughter, a son, three brothers and four sisters.

Donald L. Mahanna, M. D., Columbus; Western Reserve University School of Medicine, 1936; Aged 45; died November 19; member of the Ohio State Medical Association, the American Medical Association; fellow of the American College of Physicians; first president of the Columbus Internists Association; member of the Ohio State Heart Association and the Central Ohio Heart Association; diplomate of the American Board of Internal Medicine. Dr. Mahanna was a practicing physician in Columbus and clinical professor of medicine at Ohio State University College of Medicine. He was a member of Phi Rho Sigma, Kappa Sigma, the Catholic Church, Knights of Columbus, Holy Name Society and president of the Watterson High School PTA. Survivors include his widow, two daughters, two sons, his parents and three brothers.

Robert W. Pratt, M. D., Hillsboro; Starling Medical College, Columbus, 1897; aged 89; died November 6; member of the Ohio State Medical Association and the American Medical Association;recipient of the OSMA 50-Year Award. Dr. Pratt practiced medicine for more than a half century in Highland County, principally in Pricetown and Hillsboro. He was a member of the Masonic Lodge and the Methodist Church. Surviving are his widow, three daughters and a son.

John H. Pumphrey, M. D., Clayton, Starling Medical College, Columbus, 1901; aged 83; died

November 17; member of the Ohio State Medical Association and the American Medical Association. Dr. Pumphrey had been a practicing physician in the Clayton area for more than 50 years and had been honored by the Montgomery County Medical Society with the 50-Year Pin of the OSMA. Survivors include his widow and three sons, one of whom is Dr. Robert E. Pumphrey, of Dayton.

Herman S. Rhu, M. D., Tucson, Ariz.; Western Reserve University School of Medicine, 1899; aged 79; died November 7; member of the Ohio State Medical Association and the American Medical Association. Dr. Rhu served his entire professional career in Marion and vicinity where he was associated for many years with his father, the late Dr. Auguste Rhu. He had been honored with the 50-Year Award of the Ohio State Association. A veteran of World War I, he was a member of the American Legion. Other affiliations included membership in the Masonic Lodge and the Presbyterian Church. Surviving are his widow, a daughter and his son, Dr. Herman S. Rhu, Jr., with whom he made his home in Tucson.

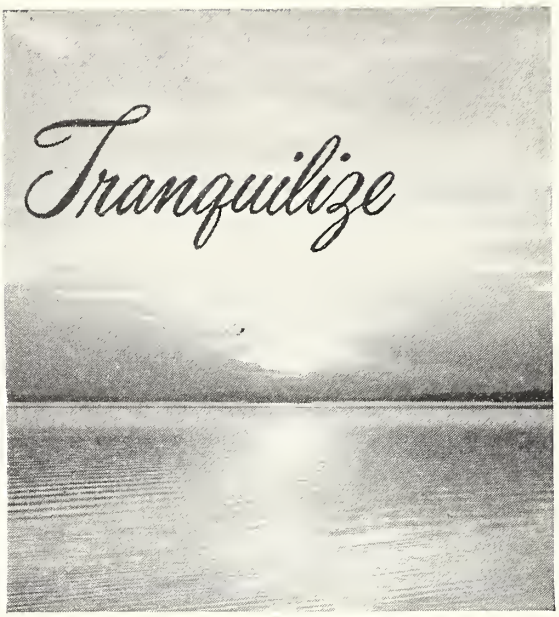
Oral H. Stone, M. D., Toledo; Harvard Medical School, 1940; aged 44; died November 18; member of the Ohio State Medical Association and the American Medical Association; fellow of the American College of Surgeons; diplomate of the American Board of Obstetrics and Gynecology. Dr. Stone interned at Toledo Hospital and then served with the Army Air Force during World War II. He returned to Toledo for residency training and later opened an office for private practice. Survivors include his widow, two daughters, two sons, and three brothers.

Sir Edward Appleton To Be Cincinnati Centennial Convocation Speaker

Featured speaker for the Cincinnati Academy of Medicine's Centennial Convocation March 5 will be Sir Edward Victor Appleton, Nobel Prize recipient and one of the world's leading scientists.

The Convocation will conclude the week-long celebration of the Academy's 100th Anniversary. It will be held in the Music Hall.

Principal and Vice Chancellor of the University of Edinburgh, Scotland, Sir Edward holds many honors and decorations from his own nation as well as others, including the Grand Cross of the British Empire, Knight Commander of the Bath. The 65-year-old scientist received the Nobel award for physics in 1947. Besides degrees from Cambridge, he holds doctors of science degrees from Oxford, Leeds, Brussels and Sidney Universities. He also holds the American Institute of Radio Engineers Liebmann Memorial Prize for 1929 and the United States Medal of Honor for his achievements in physics.



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Activities of County Societies . . .

First District

(COUNCILOR: FRANK H. MAYFIELD, M. D., CINCINNATI)

CLERMONT

Speaker for the November meeting of the Clermont County Medical Society was Dr. Walter B. Rugh, Cincinnati. His topic was "Office Gynecology."

HAMILTON

The Academy of Medicine of Cincinnati will observe the 100th anniversary of its beginning with a week-long celebration February 27-March 5, 1957. The Centennial Exposition public events will be in Cincinnati's historic Music Hall, which has attained world renown as the home of the Cincinnati Symphony Orchestra and of the Cincinnati May Festival of music.

There will be a 175-booth exhibition embracing participants from the fields of science, research, medicine, health, community service and related areas of education, business, industry and the like. The Centennial Exposition will be free to the public with special escorted visitation for school children's groups.

Educational movies and informative lectures on medical, science and health subjects will be given during the exposition with utilization of the Springer Auditorium facilities accommodating as many as 4200 at one sitting.

The exhibition of "Juno," a transparent plastic depiction of the female body will be of wide interest. This educational health exhibit which makes clear all the bones, veins, arteries, nerves, lymphatic system and principal internal organs has been loaned to the Cincinnati Academy by the Dominican Republic where it has been on exhibit during the 1956 Dominican International Exposition. The "Juno" exhibit, which operates with electronic controls, also embraces a message accompanying each 15 minute description of the processes and functions of the various parts of the female anatomy.

The American Museum of Atomic Energy, Oak Ridge, Tenn., is providing a 4000 square feet exhibit highlighting "Atoms for Peace."

Visiting speakers of the medical profession have been invited to address public evening meetings during the Centennial week.

Speaker for the December scientific meeting of the Academy of Medicine of Cincinnati was Dr. Kenneth W. Warren, surgeon, Lahey Clinic, New England Baptist Hospital, New England Deaconess Hospital, Boston, Mass.

Dr. Warren's topic was "A Panorama of Benign Pancreatic Disease; Recognition and Treatment."

On January 15, Professor James A. Reyniers, research professor of bacteriology and director, Lobund Institute, University of Notre Dame, will address the Academy on "Life in a Germ-Free World."

On February 5, Professor Reginald C. McGrane, head of the Department of History, University of Cincinnati, will address the Academy on "The First Century of the Academy of Medicine of Cincinnati."

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

CLARK

The Clark County Medical Society voted at the November 19 meeting to increase dues $5 a member yearly to establish a welfare fund for the benefit of members and families who because of death or other circumstances suffer straitened financial positions. The need for such a fund became apparent about a year ago after the death of an intern. Members of the Society donated more than $500 to the intern's family.

The Society voted to establish the fund upon recommendation of an economic committee headed by Dr. Paul W. Schanher, Jr.

In annual business conducted at the November meeting, Dr. John D. LeFevre was installed president. Dr. E. W. Schilke was chosen president-elect to head the Society in 1958.

Speaker for the scientific portion of the meeting was Dr. Howard P. Taylor of Cleveland. His subject was "Interpretation of Clinical Signs and Symptoms in Toxemias of Pregnancy."

Dr. Frank W. Anzinger, Jr., retiring president, presented a progress report for 1956. Principal activities listed in the report were:

Publication of the "History of the Clark County Medical Society."

Activation of a Lay Diabetic Association, cooperation with the American Heart Association and reactivated interest in the local Cancer Society.

Preparation of biographies of society members and organization of a speakers bureau.

A stepped-up program of public relations.

Co-operation with the Community Welfare Council in forming a community blood bank.

DARKE

"The Doctor and the Law" was the topic for the November meeting of the Darke County Medical Society, held in White Shrine Temple, near Greenville. An insurance company representative spoke on malpractice precautions.

MIAMI

"Management of Streptococcal Infection and Its Complications," a kinescopic recording of a closed circuit television symposium, was the scientific subject for the December 7 meeting of the



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Miami County Medical Society, held at Dettmer Hospital, Troy.

On January 3, the society held its annual joint meeting with the Shelby County Medical Society at the Fort Piqua Hotel.

MONTGOMERY

Discussion of care and Aid to Aged was held by the Montgomery County Medical Society at its regular meeting December 19. Annual election of officers also was conducted.

On November 21, Dr. D. C. Caudill spoke on "Thrombophlebitis" before members of the Dayton Obstetrical and Gynecological Society. On November 27, members of the Dayton Surgical Society heard Dr. Arthur G. James, assistant professor of surgery, Ohio State University College of Medicine, speak on "Management of Head and Neck Tumors" and Dr. Joseph A. Bonta, instructor in surgery at the same college, speak on "Adrenalectomy for Advanced Carcinoma of the Breast."

Dr. Russell L. Dicks, one of four Americans cited in 1955 for outstanding achievement by the National Council of Churches of Christ, addressed a joint meeting of the society and its Auxiliary December 12. Dr. Dicks is professor of pastoral care at the Duke University Medical School and is chaplain of Duke Hospital.

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

MERCER

Dr. Robert M. Fell is president of the Mercer County Medical Society for 1957. President-elect is Dr. Donald Fox and secretary-treasurer is Dr. Julius Schwieger.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

AUGLAIZE

Dr. W. V. Barton of St. Marys has been elected 1957 president of the Auglaize County Medical Society. Other officers include Dr. Robert Herman, Wapakoneta, vice-president, and Dr. D. L. Kile, St. Marys, secretary-treasurer.

LUCAS

Two section meetings and a postgraduate lecture were held during December by the Academy of Medicine of Toledo and Lucas County. Speaker for the lecture series was Dr. Henry T. Ricketts, professor of medicine, University of Chicago, who spoke on "Diagnosis and Treatment of Diabetes and Its Complications."

Dr. Grover Swoyer, director of the Newark Hospital Department of Pathology, addressed the Pathology Section on "The Chemistry, Application, and Significance of the Non-Protein Nitrogen and Nitrogenous Protein."

The Medical Section heard Dr. Richard Schafer, Toledo, speak on "Newer Concepts in Diagnosis and Treatment of Leukemia and Lymphonia."

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

ASHTABULA

Dr. Harold C. Franley of Jefferson was elected President of the Ashtabula Medical Society at the December meeting.

Dr. Walter J. Brown, Conneaut, was elected vice-president and Dr. Arthur B. Shaul, Ashtabula, was elected secretary-treasurer.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

Insulin is still the best treatment for diabetics, Dr. Geo. J. Hamwi, associate professor of medicine and chief, Division of Endocrinology and Metabolism, Ohio State University College of Medicine, told members of the Mahoning County Medical Society at their annual November meeting.

Dr. Hamwi said that while more than 200 new medicines have been developed in the treatment of diabetes, all still are in the research stage.

His address climaxed "Diabetes Week," during

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES—WINTER, 1957

SURGERY—Surgical Technic, two weeks, Jan. 28, Feb. 11. Surgery of Colon & Rectum, one week, Mar. 4. General Surgery, one week, Feb. 11. Surgical Anatomy & Clinical Surgery, two weeks, Mar. 11. Surgical Pathology, 2 or 4 weeks, by appointment. Fractures & Traumatic Surgery, two weeks, Mar. 11. Gallbladder Surgery, three days, Apr. 8.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Feb. 11. Vaginal Approach to Pelvic Surgery, one week, Feb. 4. General & Surgical Obstetrics, two weeks, Feb. 25.

MEDICINE—Electrocardiography & Heart Disease, two-week basic course, Mar. 11. Gastroenterology, two weeks, May 13; Gastroscopy, two weeks, Mar. 18.

RADIOLOGY—Diagnostic X-Ray, two weeks, Feb. 4. Clinical Uses of Radioisotopes, two weeks, May 6. Radioactive Iodine, one week, Apr. 1.

UROLOGY—Two-week course, Apr. 1. Gynecology, ten days, by appointment.

PEDIATRICS—Two-week general course, May 13.

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which members of the society led a campaign to find unknown diabetics.

SUMMIT

Dr. Charles L. Martin, professor of radiology at the Southwestern Medical School of the University of Texas, spoke on "Treatment of Cancer of Face, Mouth and Neck" before members of the Summit County Medical Society December 6. The meeting was held in Akron General Hospital auditorium and followed a dinner at the Akron City Club.

Dr. Robert G. McCready is the 1957 president of the society. Dr. Arthur Dobkin is president-elect and Dr. A. F. Dorner is past-president. Dr. Ross Zeno is secretary and Dr. George H. Bischoff is treasurer.

Elected councilors were Drs. Ralph E. Wetzel, Glenn V. Hough and Edwin W. Cauffield. Elected delegates were Drs. Donald I. Minnig, H. Oliver Musser, Carl C. Nohe, and Philip B. deMaine and Harold E. Muller. Elected alternates were Drs. H. Willard Allison, Robert J. Burkhard, Donald M. Traul, Maurice G. Wince and Paul E. Cheek.

TRUMBULL

Dr. Charles L. Hudson, Cleveland, Past-President of OSMA, was guest speaker November 20 at a combined meeting of the Trumbull County Medical Society and the Trumbull County Pharmaceutical Association.

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D., LANCASTER)

FAIRFIELD

The November meeting of the Fairfield County Medical Society was held at the Lancaster Country Club. Following a dinner, Dr. A. G. James, of Ohio State University, gave a lecture on "Tumors of the Face and Neck."

Dr. William D. Monger, Lancaster, Eighth District councilor, in behalf of the OSMA, then presented a certificate and pin to Dr. H. C. Ashton, of Basil, honoring his 50 years in practice,

Guests were Dr. Addison Kefauver, medical director of the State Industrial Commission, and Dr. Frank H. DeLand, Columbus. Dr. W. D. Nusbaum was program chairman.

MORGAN

Dr. Asa Whitacre, Chesterhill, was elected president of the Morgan County Medical Society December 3, succeeding Dr. C. E. Northrup, McConnelsville. Dr. Northrup was elected secretary-treasurer.

Dr. Henry Bachman, Malta, was elected delegate and Dr. Northrup was elected alternate.

WASHINGTON

Dr. George Gale, of Newport, and Dr. J. B. Penrose, of Marietta, were presented Ohio State Medical Association 50-year membership pins at the November meeting of the Washington County Medical Society. The presentation was made by Dr. William Monger, Lancaster, Eighth District Councilor, of the Ohio State Medical Association.

JACKSON

Members of the Jackson County Medical Society strongly urged all avenues of action be taken by the County Board of Health November 29 to control an outbreak of rabies in the county. The Society called for wider vaccination of dogs and control of stray dogs.

During the meeting, Dr. A. R. Hambrick of Wellston was elected president, Dr. John Cook of Oak Hill was named vice-president and Dr. B. J. Allison, county health commissioner, was continued as secretary-treasurer.

SCIOTO

"Cancer of the Cervix" was the topic for the November meeting of the Scioto County Medical Society, with Dr. Louis Chaboudy in charge of the program. The meeting was held in Portsmouth General Hospital.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

RICHLAND

The regular meeting of the Richland County Medical Society was held on November 15 at the Westbrook Country Club in Mansfield, in conjunction with the North Central Ohio Pharmaceutical Association.

The program of the evening consisted of a talk on relations of the physician and the pharmacist by Dr. Arthur Tye, Associate Professor of Pharmacy at Ohio State University, Columbus, Ohio. Mr. Frank Bedford of Australia was a guest and gave interesting remarks on the program of government medicine in Australia.—Charles F. Curtiss, M. D., Secretary.

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President-Elect—Mrs. V. R. Frederick, 145 Tanglewood Dr., Urbana
Vice-President: 1—Mrs. C. H. Bell, Mansfield
2—Mrs. W. R. Gibson, Oak Harbor
3—Mrs. C. A. Colombi, Cleveland
Recording Secretary—Mrs. Lester W. Sontag, Livermore St., Yellow Springs
Corresponding Secretary—Mrs. Earl Young, 170 Brookline Ave., Youngstown
Past-President and Finance Chairman—Mrs. Karl Ritter, 1420 Shawnee Rd., Lima

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ALLEN

The Allen County Auxiliary had an evening meeting on November 27 with Mrs. H. C. Kingsbery, (president-elect of the county). Three new members were added: Mrs. R. J. Kobs, Mrs. Gail Miller, Mrs. L. N. Irvin. The program was on Community Health, in charge of Mrs. Harry Warshawsky.

The Auxiliary is cooperating with Red Cross and the Medical Academy and will collect sample drugs from all doctors to be sent for Hungarian Refugee Relief. Also members will contribute warm used clothing to Red Cross for Austria-Hungary relief.

CLINTON

Mrs. J. K. Williams and Mrs. C. E. Kinzel were hostesses for the November meeting, November 6, at the General Denver Hotel, of the Woman's Auxiliary to the Clinton County Medical Society.

Speaker for the meeting was Mr. Frederick J. Buckley whose timely subject was "Legislation."

Mrs. Nathan S. Hale, president, conducted the business meeting when she reported on the October district meeting held at Middletown. The committees for the Clinton Memorial Hospital Guild Fall Festival were made and Mrs. R. R. Buchanan, project chairman, received completed articles for the sale. Mrs. E. K. Yantes gave a report of plans for decorating the booth. Mrs. V. E. Hutchens, general chairman of Twig I, made final arrangements for selling on the day of the festival. Her special thanks went to Mrs. Foster J. Boyd for posters placed in merchants' windows for advertising purposes.

COSHOCTON

On Saturday night, November 3, members of the Woman's Auxiliary to the Coshocton County Medical Society entertained their husbands with a covered dish dinner in the home of Dr. and Mrs. William Pfaadt. The twenty members and guests present enjoyed an evening of cards following the dinner.

ERIE

At the Erie Auxiliary meeting on November 6, state officers and others present became members of the "Safe Drivers League." Mrs. W. R. Gibson, Oak Harbor, 2nd vice-president; Mrs. L. G. Parker, Sandusky, district director; Mrs. V. R. Frederick, Urbana, president-elect; Mrs. William H. Evans, Youngstown, president, and Mrs. C. H. Bell, Mansfield, 1st vice-president, were the state officers who were present.

Jerry B. Williams of the Ford Motor Company presented the program talk on "Safety." Mrs. Evans and other visitors discussed phases of auxiliary activity interesting to each of the county organizations.

Mrs. C. E. Swanbeck, a member of the Erie County Auxiliary hostess committee for the day, offered an inspiring prayer before luncheon, which was one written especially for women.

FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Society met November 12 for a luncheon meeting in the Pine Room of Hotel Lancaster.

The business meeting was conducted by the president, Mrs. C. R. Reed. Mrs. Kenneth Gaines gave a report on *Today's Health*, and Mrs. Richard A. Welsh reported on Civil Defense. The group held a discussion on the nurses' scholarship which it awards. The committee for the meeting was Mrs. J. L. Kraker, Mrs. C. F. Clark, Mrs. A. M. Kelley, and Mrs. George Mogil.

On October 23, the Medical Auxiliary held its annual Fall Party for the freshman class of nursing students in the recreation room of the Nurse's Home. After favors were presented to each student, Mrs. Chester Swett showed slides of Yellowstone National Park. Twenty-two nurses were present.

Mrs. William Jasper was chairman; serving on her committee were Mrs. C. H. Hamilton, Mrs. Chester Swett, and Mrs. Robert Bode.

FRANKLIN

Members of the Woman's Auxiliary to the Columbus Academy of Medicine displayed their hobbies at a meeting November 19, at the Columbus Gallery of Fine Arts.

Mrs. Earl H. Baxter brought to the show a charcoal sketch of a mother and child. She does almost all of her art work in charcoal and pastels and is studying figure and anatomy drawing at the Columbus Art School.

Several water color pictures were done by Mrs. James H. Warren, who has been painting in that medium for the past 10 years.

Mrs. Robert W. Bohl displayed a water color still-life and several attractive looped rugs.

Before moving to Columbus six years ago, Mrs. James W. Papez taught art in Ithaca, N. Y. She makes ceramic ware.

One of the most interesting displays was some

pieces of Whieldon ware owned by Mrs. John A. Whieldon, Worthington.

Copper enameling is a hobby enjoyed by Mrs. William H. Saunders, who makes earrings and pins in bright colors. Mrs. George Peters filled a table at the gallery with a large collection of unusual glass bottles. Mrs. Henry E. Wilson displayed a small part of her collection of old coins and Mrs. George Morrice, a Dixieland jazz enthusiast, brought a group of her favorite records.

Also at the show was wearing apparel sewed by Mrs. Charles J. McKitrick, and knitting done by Mrs. Alexander Pollock and Mrs. James J. Conn. Mrs. Edward Turner displayed several old quilts.

"Charitable work can be a hobby too," read a small sign pinned to a large number of buckeye and ribbon pins made by Mrs. Willard Andrus. Mrs. Andrus is a member of the Women's Juvenile Service Board which sells these pins at football games, with the purpose of raising money to combat juvenile delinquency in Franklin County. As her hobby, Mrs. Philip B. Hardymon displayed pictures of her five sons.

Mrs. W. Hugh Missildine and Mrs. Edwin R. Zartman were in charge of arrangements for the show.

HAMILTON

The second fall luncheon meeting of the Woman's Auxiliary to the Hamilton County Medical Society was held on November 20 in the Hotel Gibson ballroom.

Following luncheon, Mrs. Calvin F. Warner presided at a business meeting. The nominating committee was elected. Mrs. Frank Mayfield served as chairman of tellers. Mrs. William Hunting, as vice-president, assisted with the election.

President-elect, Mrs. Gaston B. Hannah, assisted by Mrs. Charles O. Carothers and Mrs. Warner A. Peck, Jr., introduced new members to the Auxiliary.

Mrs. Joseph Peil, from Middletown, the First District Director of Ohio State Woman's Auxiliary, was the guest of honor.

A report was given by Mrs. Charles W. Hoyt on the December Dance. Mrs. Earl C. Van Horn, chairman of the Philanthropic Committee, reported on her committee.

Mrs. George W. Ballou gave a report on *Today's Health*. As chairman of New Members, Mrs. Kent E. Martin gave a report on the orientation group.

Mrs. Robert E. Kotte introduced the speaker of the day, Mr. Harold Howe II, principal of Walnut Hills High School, whose subject was "Young People Today."

Mrs. Glenn Pfister, Jr., hospitality chairman of the day and her vice-chairman, Mrs. Howard C. Pfister, were assisted by Mrs. William Culbertson, Mrs. Jerome Jansen, Mrs. Norbert Cavanaugh and Mrs. Arthur Spreen.

Mrs. John M. Glenn was responsible for the lovely table decorations assisted by Mrs. Robert E. Khuon and Mrs. Bert McBride.

HARDIN

Local color predominated in decorations in the friendly atmosphere of Memorial park clubhouse on November 8 as Mrs. Floyd Elliott, president of the Hardin County Auxiliary and the Auxiliary's past presidents received 55 members and five guests of Ohio's Third District Medical Auxiliary attending the first such luncheon conference to be held in Kenton.

Mrs. W. R. Gibson spoke briefly describing the organization, its advantages in recruiting possibilities and stressed the importance of good relations with other groups. There are 10 organized groups and one unorganized group in the Third District.

Mrs. Mills then introduced the afternoon's speaker, Mrs. William Evans of Youngstown, president of the State Auxiliary. Her excellent talk touched upon the principal points of the 13th annual national conference of state presidents which she attended October 1-2 at Chicago.

HURON

The Woman's Auxiliary to the Huron County Medical Society met at the Plum Brook Country Club, November 6. This was the meeting for the 11th District under the leadership of the district director, Mrs. Lester Parker.

The State President, Mrs. William Evans was present with an excellent report from the Chicago meeting of National Officers.

Mr. Williams of the Ford Motor Company spoke on "Safety" and told of the many safety measures the Ford Company has built and is continuing to build into the Ford Car. He also spoke on the many highway improvements which are going on with "built-in" safety.

KNOX

Mrs. Joseph Allman was hostess November 20 to the Auxiliary of the Knox County Medical Society, with Mrs. Charles Bammerlin and Mrs. James Kennedy as co-hostesses.

During a business session with Mrs. George Imhoff presiding, it was voted to send subscriptions to *Today's Health* magazine to all county high schools, and a donation to the Tuberculosis and Health Association.

Mr. Randall Schunk of the Chamber of Commerce showed a film.

LICKING

Licking County Medical Auxiliary met on November 27 at the home of Mrs. J. R. Wells. Members brought more than 100 gifts (Christmas items) to be sent through the Moundbuilders Guidance Center, Newark, Ohio, to the Columbus State Hospital. Since the Mound-

builders Guidance Center was just opened this year for use of the community, the organization is adopting it as another project. A list of suggested items was passed out to each member. The list included things that could be used for therapy treatment for adults or children, and also personal items needed for patients at the Columbus State Hospital.

LUCAS

Dr. Mary Ellen Goodman, Chevy Chase, Md., anthropologist, spoke at the annual tea and open meeting of the Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County on November 13 in the Academy Bldg.

In discussing the subject, "Our Child Centered Society: Time for Reappraisal," Dr. Goodman said many parents "have gone overboard on extreme permissiveness."

Dr. Goodman was introduced by Mrs. Rollin Kuebbeler, program chairman.

Between 60 and 70 organizations sent representatives to the meeting, which was followed by tea. Former past presidents of the Auxiliary presided at the tables.

MAHONING

While their husbands attended lectures at Stambaugh Auditorium on October 24 in connection with Mahoning County Medical Society's Post Graduate Day, members of the Woman's Auxiliary to the Sixth Counselor District were entertained at a day-long program arranged in their honor by the Woman's Auxiliary to the Mahoning County Medical Society, Mrs. Paul J. Mahar, president.

Over 160 doctors' wives from Summit, Stark, Columbiana, Trumbull, Portage and Mahoning Counties attended the festivities which opened with a coffee hour in the morning in the Jade Room of the V. F. W. Club.

At noon the company gathered for a gala luncheon, also in the Jade Room and heard a talk on "Rocks in Your Head" by Warren Guthrie, Cleveland newscaster. Seventeen tables were set up for luncheon, each bright with fall flowers in horns-of-plenty. Mrs. Craig Wales, chairman for the day's events and past-president of the Auxiliary, introduced Mr. Guthrie.

On November 10, a scholarship dance was held at Squaw Creek Country Club attended by 224 medical men, their wives and guests.

The dance featured a continuous buffet, music by Lou Sikora's orchestra, and special entertainment by Woods and Bray, "Wonder Dancers" who gave their interpretation of modern dance steps.

MIAMI

Area high school girls interested in nursing as a profession were entertained with a tea on November 6 at the Altrurian club by the Woman's Auxiliary to the Miami County Medical Society.

The event is given annually by the Auxiliary to stimulate interest in nursing careers. Highlight of the tea was a talk by Capt. Lorraine B. Robertson of the U. S. Army medical corps, nurse procurement officer for Ohio.

Miss Janet Stephen and Miss Barbara Hoban, student nurses at Good Samaritan and St. Elizabeth hospitals respectively, gave interesting accounts of their experiences as student nurses.

Each year the Auxiliary sponsors a qualified girl for a four-year course in nursing at an accredited school of her choice. In return, the girl agrees to practice her profession in Miami County for at least a year after completion of her studies.

RICHLAND

W. C. Leonard, safety adviser for the Industrial Commission of Ohio, Division of Safety and Hygiene, spoke on industrial safety at a meeting of the Woman's Auxiliary to the Richland County Medical Society November 5 at the Women's Club. Thirty-eight members attended the luncheon.

The speaker cited different measures on the prevention of accidents and supplemented his talk with illustrations and pictures of accidents which occurred in industrial plants.

Following the program, Mrs. F. M. Wadsworth, president, conducted the business session during which club projects were discussed. The Auxiliary will contribute money raised from the projects to the American Medical Educational Fund.

SUMMMIT

Woman's Auxiliary to Summit County Medical Society had a luncheon meeting, November 6, in Akron City Club.

Mrs. A. H. Loomis introduced the guest speaker, Dr. Paul L. McKay, pastor of First Presbyterian Church. His subject, "Cracks in the Kremlin Wall," was based on his travels to Russia earlier this year.

TUSCARAWAS

Mrs. Thomas Ogden of Gnadenhutten and Mrs. Richard Whittington of Berea were guests when the Woman's Auxiliary to the Tuscarawas County Medical Society met on November 8 at the home of Mrs. Paul Ebert in Dover.

Mrs. Benjamin Pilloff of Uhrichsville presided over the business meeting, when plans were made for making Christmas baskets for patients at the TB sanitarium. Mrs. C. J. Miller is chairman of the project, which has been an annual activity of the Auxiliary for a number of years.

A history of the orthopedic clinic, which originated seven years ago, and which has been sponsored by the local Auxiliary, was outlined by Mrs. M. W. Everhard of this city. The clinic is held twice monthly at Union hospital, with patients being referred by their own per-

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sonal physician or health nurse. Members of the Auxiliary take care of the clerical work.

During the program, Mrs. J. Martin of Dover gave a highly informative address concerning the Philippine Islands, which she illustrated with slides on the customs and every-day life. Mrs. Martin, with her husband, Dr. Martin, lived on the islands for some time.

Bunts Institute in Cleveland Announces Courses

The Frank E. Bunts Educational Institute, affiliated with the Cleveland Clinic Foundation, has announced three postgraduate courses for early 1957. They include a course on general practice, one on otolaryngology, and one of particular interest to dentists.

The fourth annual course, entitled "General Practice," will be held at the Institute, 2020 East 93rd Street, Cleveland 6, February 6 and 7. This course, open to all members of the medical profession, is sponsored by the Cleveland Chapter of the American Academy of General Practice and has been approved for 10 hours credit. Registration fee is $15. Reservations should be addressed to the registrar at the foregoing address.

The GP course on Wednesday morning, February 7 includes: A panel discussion on psychiatric medicine, including discussions of the anxious patient, the timid patient, the agitated senile patient and the function of tranquilizers. Also on the morning schedule are the following subjects: Facets of pediatric diagnosis, hearing problems in children, obstetrical management of abnormal presentations, detection methods in pelvic cancer and the treatment of sinus diseases.

The Wednesday afternoon program includes panel discussions on hypertension and open heart surgery.

On Thursday morning, February 7, two panels are scheduled. The first on medicine includes discussion of the following subjects: The painful leg, progress in the management of rheumatoid arthritis, some aspects of the problem of fever of unknown origin, and treatment of some common skin diseases. Under surgery, these subjects will be discussed: Reversible hypertension, the acute abdomen, care of colostomies and the orderly approach to the injured individual.

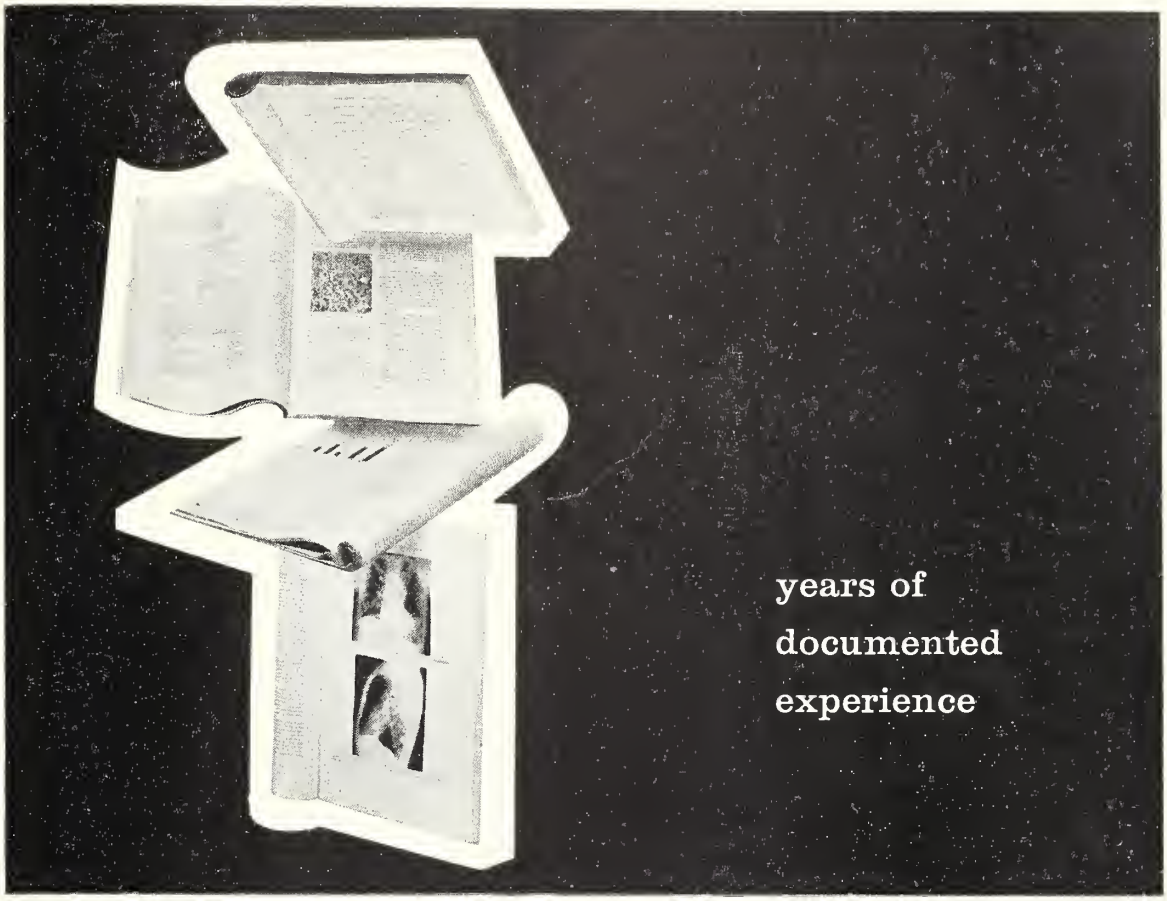
On Thursday afternoon there will be a tour of Cleveland Clinic and Cleveland Clinic Hospital.

The course entitled "Otolaryngology" is scheduled February 27 and 28. It should be of interest to general practitioners and specialists in otorhinolaryngology. Registration fee is $15. Details of this and the other courses may be obtained from the Institute.

The course entitled, "Medical Program and Its Relationship to Dentists," will be held on March 13 and 14. This is the second annual presentation of the course which will be of particular interest to dentists.

INDEX TO ADVERTISERS

Abbott Laboratories ... 88 - 89
American Meat Institute ... 26
Ames Company, Inc. ... 14
Ann Arbor School ... 120
Appalachian Hall ... 126
Ayerst Laboratories, Inc. ... 92
Bayer Company, The Div. of Sterling Drug Co., Inc. ... 119
Burroughs Wellcome & Co. (U.S.A.) Inc. ... 32, 99, 123
Chicago Medical Society ... 81
Ciba Pharmaceutical Products, Inc. ... 118
Cincinnati Sanitarium ... 27
Columbus Pharmacal Company ... 101
Cook County Graduate School of Medicine ... 108
Davies, Rose & Co., Ltd. ... 98
Endo Products, Inc. ... 125
Ethicon, Inc. ... 113
Flint, Eaton & Company ... 122
Foot-so-Port Shoe Company ... 120
Geigy Pharmaceuticals, Inc. ... 34
General Foods Corporation (Sanka) ... 16
Harding Sanitarium ... 30
Health-Mor, Inc. ... 13
Hoffmann-LaRoche, Inc. ... Insert between pages 64 - 65
Knox, Chas. B., Gelatine Co., Inc. ... 117
Lakeside Laboratories, Inc. ... 1
Lederle Laboratories ... 19, 29, 66 - 67
Liebel-Flarsheim Co. ... 35
Lilly, Eli, and Company ... 36
Magnetic Springs Foundation ... 107
Mallard, Inc. ... 103
McMillen Sanitarium ... 30
Medical Protective Company ... 120
Merck Sharp & Dohme 5, 6, 7, 8, 9, 10, 24-25, 96, 121
Merrell, The Wm. S., Company ... 87
Neil Training School ... 109
New York Polyclinic Medical School ... 93
Parke, Davis & Company ... 128 and Inside Back Cover
Pfizer, Chas. & Co., Inc. ... 33, 85, 104 - 105
Pogue, Mary, School, Inc. ... 124
Quincy X-Ray & Radium Lab. ... 115
Rawl Chemical Company ... 93
Riker Laboratories, Inc. ... 91
Robins, A. H., Co., Inc. ... 15
Sawyer Sanatorium ... 28
Schering Corporation ... 17
Scroggins, Clayton L., Associates (Medical-Dental Management) ... 12
Searle, G. D. & Company ... 79
Smith, Kline & French Laboratories ... 23, 127, and Back Cover
Squibb, E. R. & Sons, Division of Olin-Mathieson Chemical Corporation ... 116
Stoneman Press ... 124
Tutag, S. J. & Company ... 126
United Fruit Company ... 11, 12
Upjohn Company ... 3
Wallace Laboratories ... 31
Wendt-Bristol Company ... 120
Windsor Hospital, Inc. ... 124
Winthrop Laboratories ... 81, 107
Year Book Publishers, The, Inc. ... 22



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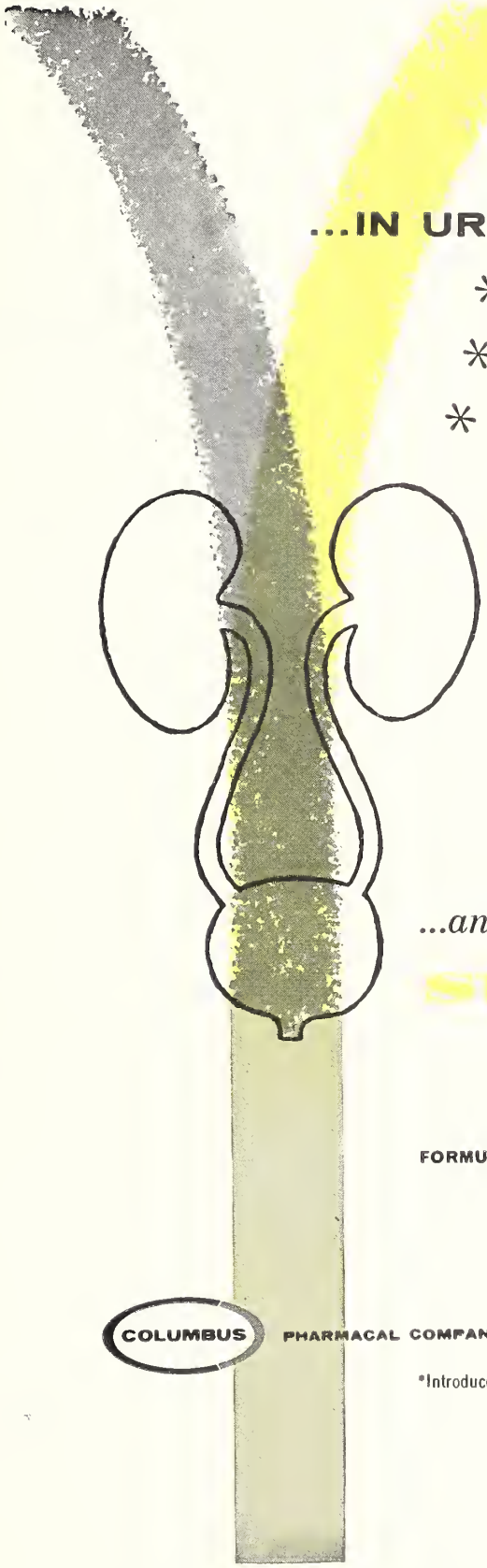
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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

Essays in Biochemistry, edited by Samuel Graff, ($6.50. *John Wiley and Sons, 440 Fourth Avenue, New York City, 16, N. Y.).* Twenty-seven leading authorities have attempted to survey our position in this field and to point out the probable future. Consequently, there is an extraordinary range of subject matter; authoritative insight in specialized branches of biochemistry—all this done to honor Hans Thacher Clarke on the occasion of his retirement as Professor and Chairman of the Department of Biochemistry, College of Physicians and Surgeons, Columbia University.

Effects of Alcohol on the Nervous System of Man, by Cyril B. Courville, M.D., ($4.50. *San Lucas Press, Los Angeles, Calif.),* is a report based upon 123 cases seen from October 1, 1953, to March 31, 1955, but does not include a large number of additional cases in which alcohol may have had a part in final termination.

Administrative Medicine: Transactions of the Third Conference, ($3.00. *Josiah Macy, Jr., Foundation, Packanack Lake, N. J.).* Deals with special characteristics of medical administration problems: Educational requirements; the hospital in relation to the community; business administration; principles applied to hospital administration and administrative problems of the community.

Textbook of Medical Physiology, by Arthur C. Guyton, M.D., ($13.50. Illustrated. *W. B. Saunders Co., Philadelphia, Pa.).* The purpose of this text as might be surmised by its title is to present the philosophy and logic of physiology as a series of regulatory systems integrated into one complete functioning organism, *the human body,* and in terms that the medical student can understand the whole mass of knowledge essential to the physician.

Soul Sorrow: The Psychiatrist Speaks to the Minister, by Hjalmer Helweg, M.D., ($3.00. 3rd ed. *Pageant Press, New York 36, N. Y.).* A series of lectures given at the University of Copenhagen in 1932. These pages have stood the test of time.

Brain Mechanisms in Diachrome, by Wendell J. S. Krieg, ($7.00. *Brain Books, Evanston, Ill.).* The diachrome reconstruction is quite inclusive of the known structure and connections of the brain. The textual approach is synthetic, systemic, functional and the illustrations inclusive, graphic, and three-dimensional. In order to keep prices low, the book is distributed directly on prepaid order, $7.00 a single copy or $6.00 if 10 or more copies are ordered at one time.

Prolonged and Perplexing Fevers, by Chester S. Keefer, M.D., and Samuel E. Leard, M.D., ($5.50. *Little Brown and Company, Boston, Massachusetts).* The diagnosis of prolonged fever, with or without local signs of disease, is one of the most frequently encountered problems in practice. The problem is all the more annoying, since many fevers of this nature do not respond to the new agents recently developed to combat acute infections. This helpful and unique book brings into clear focus the various means of diagnosing the most common forms of persistent fever. The effort is confined to those disorders in which the fever lasts two weeks or longer.

Bacterial Anatomy, edited by E. T. C. Spooner and B. A. D. Stocker, ($6.00. *Cambridge University Press, New York 22, N. Y.,* for the Society of General Microbiology). This is the sixth symposium of the Society, held in April, 1956. There are 15 articles in the volume, with description of the form and behaviour of the bacterial cell. This is less a matter of guesswork than it was a few years ago, since the introduction of the electronic microscope. There is still, however, much that is controversial. The book is of interest to anyone concerned with the relationship between bacteria and other living things.

Speech After Laryngectomy, Syracuse University Special Education and Rehabilitation Monograph Series 1, by Louis M. DiCarlo, Walter W. Amster and Gilbert R. Herer, ($4.00. *University of Syracuse Press, Syracuse 10, N. Y.).* This volume presents a comparative study of the breathing and speech coordinations of laryngectomized and normal subjects, and the relationships between the breathing and speech coordinations and articulatory errors of laryngectomized subjects to their speech intelligibility.

Rorschach Resumé, Rorschack Ink Blot Personality Testing, by Samuel Kahn, M.D., ($1.50. *Dynamic Psychology Society Press, (Opti-Press), Ossining, N. Y.).* The material in this volume has been gathered from lectures and notes given for a number of years by four distinguished professors in the Universities of New York, plus a reading of the standard books on the technique, with clinical interviews with private and hospitalized patients, as well as work at Quakerbridge School, and in the United States Army. It presents a thesis to which many agree, that this method of personality diagnosis is probably the quickest and most accurate technique provided it is augmented by other technical measures.

Psychosomatic Aspects of Cancer, by Harold E. Simmons, ($1.00. *Peabody Press, Washington, D. C.).* The purpose of this monograph is

that of developing an hypothesis regarding the cause and nature of cancer—that is, that cancer is caused by emotional disturbance. To develop this hypothesis, the pertinent data that is available in the literature is brought together. The lives of various persons who have had cancer are reviewed. From this basis the theory is developed by inductive reasoning. The author does not pretend to present original clinical or laboratory research, but rather to present a starting-point for further research in a new direction.

The Back and Its Disk Syndromes: Including Injuries, Diseases, Deformities, and Disabilities with notes on the Pelvis and Coccyx, by Philip Lewin, M. D., ($18.50. Second Edition. *Lea and Febiger, Philadelphia 6, Pa.).* The author has correlated and integrated facts, evaluated the theories and crystallized the concepts and misconceptions of diagnosis and treatment. He has kept the patient's viewpoint foremost at all times i. e., "What is wrong?" "What can be done about it?" and What is the outlook?"

The Complete Medical Guide, by Benjamin F. Miller, M. D., ($4.95. *Simon & Shuster Inc., New York, N. Y.).* The Director of the May Institute for Medical Research in Cincinnati has produced a comprehensive volume of medical knowledge for the layman.

The Cost of the National Health Service in England and Wales, by Brian Abel-Smith, and R. M. Titmuss, ($5.50. *Cambridge University Press, New York 22, N. Y.).* This is the first analysis of the cost of this national experiment made at the request of the Health Ministry by National Institute of Economic and Social Research. It will serve as a reference book for all who concern themselves with nationalization of the care of the sick and the creeping of socialism upon us.

Blood Group Substances: Their Chemistry and Immunochemistry, by Elvin A. Kabat. ($8.00. *Academic Press Inc., New York 10, N. Y.)* This book brings together and synthesizes existing information on blood group substances seen from the viewpoint of quantitative immuno-chemistry. This authoritative work is a must in the libraries of all physicians dealing with blood groups.

Love or Perish, by Smiley Blanton, M. D. ($1.00, paper; $3.50 cloth. *Simon and Schuster, New York, N. Y.)* Without love—in every form —the collapse of life begins. From the simple drudgery of getting up in the morning to the almost incredible disasters which lead to death, it is the author's thesis that there is clear evidence that no one can hope to survive in a life guided by hatred. With this in hand, the author distills a full career of psychiatric practice and successful guidance into a book of 200 pages for people of all kinds.

How to Relax in a Busy World: The Techniques in Reducing Tensions, by Floyd Corbin. ($1.45. *Collom Studios, Glendale 4, California.)* The book discusses nervous fatigue, tension, irritation, the reducing effects of toxins, changing mental attitudes, techniques for releasing physician tension and mental strain, shaping one's own destiny.

Ionic Interpretation of Drug Action in Chemo-Therapeutic Research, by A. V. Tolstoouhov, M. D., Ph. D. ($10.00 *Chemical Publishing Co., New York 10, N. Y.)* The growth of the art of organic synthesis and the development of the ability to produce homologues and analogues of active compounds almost at will had been associated with the tendency to explain the biological activity of drugs on the basis of a purely chemical relationship between structure and activity. Few important drugs, however, have been developed as the result of a conscious intention on the part of the chemist to proceed unerringly to a new and active compound solely on the basis of a priori considerations. It must be remembered that drugs of entirely dissimilar characteristics may possess identical actions. Furthermore, the same drug often affects the function of tissues which diverge widely in function and histochemical characteristics. In this crowded situation, this book represents a significant contribution by de-emphasizing the purely structural characteristics of initial agents and bringing into focus the role played by their physical aspects.

Regeneration in the Central Nervous System, edited by William F. Windle, Ph. D. ($9.50. *Charles C. Thomas, Springfield, Ill.)* This monograph had its inception at the Conference on Regeneration in the Central Nervous System sponsored by the National Advisory Council on Neurological Diseases and Blindness. This subject has a long history of practical interest to those engaged in basic neurological science, as well as clinical neurologists and neurosurgeons. It presents in well-edited fashion the present status of the problem as it exists in the minds of 33 of the world's leading investigators.

No Time for Fear, by Grantly Dick Read, M. D. ($3.50. *Harper & Brothers, New York 16, N. Y.)* The author of **Childbirth Without Fear** gives us an account of his travels among the tribes of Central and South America. He has gathered data on the subject of childbirth from the Africans through whose lands he passed, from doctors, missionaries, nurses, in fact from everybody who had anything interesting to tell him.

The Neuroses in Clinical Practice, by Henry P. Laughlin, M. D. ($12.50. *W. B. Saunders Co., Philadelphia 5, Pa.)* In this book the neuroses are presented in a practical manner, with case histories to illustrate important points, and bits of historical material where it seems of interest. The material and concepts presented have a per-

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Immunology and Serology, by Philip L. Carpenter. (\$6.50. *W. B. Saunders Co., Philadelphia 5, Pa.)* This is a textbook for that hybrid science, Immunology, whose ancestors include bacteriology, physiology, chemistry and physics. It is designed as a text for the students. It is an excellent presentation of current thinking in the field of infection and immunity, and will serve well any physician who wishes to review and bring himself up-to-date on this important topic.

Physical Diagnosis, by W. R. Morrison, M. D., and L. B. Chenowith, M. D. (\$5.50. 5th Edition. *Lea and Febiger, Philadelphia, Pa.)* The standard text has been revised and brought up to date. It was written primarily for those without medical training who have been given responsibility for physical examination and other procedures in the schools.

Chemistry and Human Health, by Burnham S. Walker, M. D., Isaac Asimov, Ph. D., and M. K. Nicholas, R. N. (\$5.75. *Blakison Division, McGraw-Hill Book Co., Inc., New York 36, N. Y.)* This basic chemistry text is organized from information obtained from outstanding editors in the nursing field.

The Annual Survey of Psychoanalysis, Vol. 3, edited by John Frosch, M. D. (\$10.00. *International Universities Press, New York 11, N. Y.)* A comprehensive survey in 700 pages, of current psychoanalytical theory and practice.

Surgery for Nurses, by James Moroney, M. B., Ch. B. (\$6.00 3rd edition. *E. S. Livingstone Ltd., Edinborough*, United States distributor, *Williams and Wilkins Co., Baltimore 2, Md.)* The book has been brought up to date and made to conform with the revised syllabus of the General Nursing Council. Important changes have been made in the sections on tetanus, uremia, surgery of the heart, blood transfusions, and the prevention of explosions in the operating theatre, among other things.

Histopathology of the Teeth and Their Surrounding Structures, edited by Paul Boyle, M. D. (\$10.00. 4th edition, thoroughly revised and edited. *Lea & Febiger, Philadelphia, Pa.)* The basic format has been retained in this standard text. More emphasis has been placed on tumors of the tissues of the mouth, and upon biopsy procedures. The chapter on dental caries and the one on periodontal disease have been extensively revised.

Chest X-Ray Diagnosis, by Max Ritvo, M. D. (\$16.00. 2nd ed. *Lea and Febiger, Philadelphia 6, Pennsylvania.)* In the four years since the first edition of this work was published, new diagnostic criteria and techniques have been evolved. As a result many parts of the text have been expanded or entirely rewritten. These facts make a book to be highly desired by all who examine the chest.

Education for Marriage, by James A. Peterson. (\$5.50. *Charles Scribner's Sons, New York 17, New York.)* The author, associate professor of sociology and marriage counseling in the University of Southern California aims in this work to achieve specific changes in attitude and in psychological growth, teaching *persons* rather than facts, teaching *for* marriage rather than about marriage.

Man in This World, by Hans Zehrer, (\$4.95. *New York University Press, New York, N. Y.)* For all readers here is a penetrating discussion of the forces of science and of a mechanized world that have all but mastered mankind. The author comes to some frightening conclusions but does point out a road to survival—the only one, he believes. His examination of the historical processes which have led western man to "the point of nothingness." The end of the world as we know it is never very far away from the author's mind. His pessimism is tempered, however, by a deep understanding and a deep faith in Christianity in spite of its present decay.

Principles of Psychoanalysis: Their Application to the Neuroses, by Herman Nunberg, M. D. Translated by Madlyn Karr and Sidney Kahr, M. D. (\$7.50. *International Universities Press, Inc., New York 11, N. Y.)* A book that is said to be long over-due in its translation into English. It is the book of which Sigmund Freud says, "Nunberg gives the most complete and accurate presentation we have at this time of a psychoanalytic theory of neurotic processes."

Disturbances of Fluid Balance: Their Clinical Recognition and Management, by John H. Bland, M. D. (\$11.50. 2nd ed. *W. B. Saunders Co., Philadelphia 5, Pa.)* The pyramiding mass of information both factual and conceptional in the field of water, electrolyte and hydrogen ion metabolism have made this second edition mandatory on the author as well as making the new book a must in the library of the physician.

Adventures in Staying Young, by Maxwell Maltz, M. D. (\$3.50. *Thomas Y. Crowell Co., New York 16, N. Y.)* A series of interesting case histories from the files of a plastic surgeon collected over a period of 25 years. From these the author has developed a philosophy of, and learned a means of achieving, inner youth.

Psychological Medicine: A Short Introduction to Psychiatry, by Desmond Curran and M. Partridge. (\$5.00. 4th ed. *E. & S. Livingstone Ltd., Edinburgh and London;* United States distributor, *Williams & Wilkins, Baltimore, Md.)* With the addition of the junior author, the standard text has undergone expansion and extensive revision even though the chapter on wartime psychiatry has been omitted.

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JONATHAN FORMAN, M. D., *Editor*

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Differential Diagnosis of Chest Pain

With Special Reference to Coronary Artery Disease

HERMAN S. APPLEBAUM, M. D.

PAIN in the chest is a common subjective symptom of organic disease. It may originate from disease of the cardiovascular system, lung, pleura, from pathologic conditions in the mediastinum, esophagus, trachea, diaphragm, chest wall, and abdominal organs, or from other miscellaneous causes.[1]

Coronary artery disease receives first importance because it is the commonest of heart diseases, and often the most serious one. It was formerly classified as (1) angina pectoris, (2) coronary insufficiency, and (3) coronary occlusion. Now the first two are usually considered as interchangeable and synonymous. Master[2] considers coronary insufficiency as an episode of angina pectoris, and pain results from a disproportion between the oxygen demand and the oxygen supply of the myocardium.

On this basis many factors may operate in angina pectoris. It may result from some disease within the heart or coronary vessels, or from extra-cardiac conditions. The pain (or distress, heaviness, fullness, tightness, burning, sensation of constriction) can occur retrosternally or anywhere in the chest, and even in the upper abdomen. Pain may also occur in the shoulders, arms, wrists, or even the jaw, and is precipitated by exertion or emotional stress. It may vary from the simple and transitory chest pain or pressure to severe pain and collapse, and due to prolonged and severe ischemia may result in infarction.

The severe knife-like pain is due to spasm of intercostal muscles. There may also be a vascular phenomenon, such as blanching of the fingers with or without wrist pain, or a glandular phenomenon, i. e., profuse sweating and salivation.

Submitted April 10, 1956.

The Author

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AGE

Angina pectoris may occur at any age but usually starts at about 25, and its incidence increases with age. It is more common in the younger male than in the female in the ratio of about 4 to 1; but as the years advance the female becomes just as susceptible as the male or more so. A possible explanation may be that the blood cholesterol, according to some investigators, is lower in young females but rises proportionately higher in women with advancing years.

CAUSES

There are three main causes, according to Master[2] for the onset of pain in coronary insufficiency, and the combination of the three is probably the commonest of all. The first cause is increased cardiac work such as severe exertion or emotional strain, walking against the wind, shoveling snow, excitement, overindulgence in food, tachycardia, hypertensive or hyperthy-

roid crisis, acute infection, extreme temperature, et cetera.

The second cause is diminished coronary blood flow. Clinically, shock, hemorrhage, trauma, and surgery are the most important causes; also such conditions as orthostatic hypotension, spinal anesthesia, sympathectomy, acute heart failure, reflex vasoconstriction from pulmonary embolism, peripheral embolism, and acute abdominal conditions are additional causes of diminution of coronary blood supply.

The third etiologic factor is impaired oxygenation of blood such as occurs during anesthesia, asphyxia, high altitudes, acute anemia, asthmatic attacks, pulmonary embolism, and pulmonary insufficiency. Pathologically, according to Briggs, such conditions as coronary sclerosis, coronary ostial closure, mitral and aortic stenosis, aortic insufficiency, acute congestive failure may result in diminished coronary blood flow under exertion and may precipitate an attack. This is also true of extracardiac factors.

The electrocardiogram in coronary insufficiency may be normal but often shows some abnormality during an attack, such as ST depression and T wave changes, or more often after the Master two-step exercise test,[2] but the test is not always reliable and some believe there is danger in its use. Occasionally the pain is difficult to evaluate because so many factors are involved. But the diagnosis can be made if one bears in mind that distress, or pain, follows exertion or emotional excitement and is relieved by nitroglycerin. This agent is also effective when taken prophylactically before the patient undergoes exertion which is known to cause pain.

However, there is the condition of angina decubitus — "angina of rest" and/or paroxysmal nocturnal dyspnea—that is precipitated by the recumbent positon, most often at night. This position imposes greater work on the heart, due to increased blood volume, and, together with disturbed sleep and dreams, may set up a chain reaction which may affect the heart, blood pressure, and respiration. The actual cause remains obscure, but the underlying factor is the same in angina of effort and angina of rest, viz.: decreased blood supply to the heart muscle. Watson believes that the etiology may be on the basis of salt and water retention accompanying subclinical congestive heart failure with diminished cardiac output and markedly diminished renal function. He therefore suggests treating this condition with low sodium and any of the various diuretics. Levine, however, sees no useful purpose in this division of "angina of effort" and "angina of rest."

CORONARY OCCLUSION

Coronary occlusion, however, according to Master[2] and others, has no precipitating factor other than shock or shock-like states. This condition is distinct and separate from coronary insufficiency. It is believed to be the end stage of long-standing coronary arteriosclerosis and thus cannot be prevented.[2] However, I believe that the fatal result might be delayed in some patients by avoiding exertion or emotional excitement. Frequent attacks of prolonged angina (15 to 30 minutes) unrelated to effort may represent prodromes of acute coronary occlusion or its actual onset.

The clinical picture of coronary occlusion is well known, so I need mention these features only briefly. The onset of pain is sudden (most often substernal), severe, and prolonged, not only not relieved by nitroglycerin but may be aggravated by it. Nausea and vomiting are common; temperature becomes elevated, the heart signs are weak, embryocardia, gallop rhythm, pericardial friction, arrhythmias, and tachycardia may occur. Blood pressure usually falls; left heart failure is common.

The laboratory findings are leukocytosis, rapid sedimentation rate, and prolongation of the circulation time. The characteristic electrocardiogram findings, when present, are ST elevation, deep Q waves, and inverted T waves; whereas in acute coronary insufficiency these findings are usually absent or slight, and the blood pressure remains the same or is slightly elevated. Also in acute coronary occlusion the endocardium is also damaged.[2] Hence mural thrombosis and embolism are frequent.

In coronary insufficiency the *sub* endocardium is involved, hence no mural thrombosis or embolism. If there is a rich collateral circulation coronary thrombosis will *not* lead to infarction. An unusual experience I had with one patient who had four attacks of myocardial infarction without any pain whatever. Each attack was initiated by an attack of pulmonary edema, and the electrocardiogram was consistent with myocardial infarction. The patient expired in the fourth attack and autopsy showed very extensive evidence of old and recent myocardial infarction and thrombosis in the right and left conorary arteries.

INCIDENCE

Is coronary disease on the increase? It seems so from the number of coronary deaths reported in the newspapers. Enos et al.[3] examined the coronary vessels of 300 supposedly healthy soldiers who died of trauma, and found that 77.3 per cent showed some gross evidence of arteriosclerosis. The disease process varied from fibrous thickening to large atheromatous plaques causing complete occlusion of one or more major vessels. The average age in 200 of the soldiers was 22.1 years; the oldest was 48 years and the youngest 18. None of these had complained of angina pectoris.

This is a surprisingly large incidence of cor-

onary disease in young people, which might explain the frequency of coronary deaths in this age group. It is conceivable that many of these men, had they lived, might have developed before long, clinical evidence of coronary occlusion. One factor is quite obvious: people live much longer now, at a time when coronary disease is more common; hence there will be more deaths from this condition.

PULMONARY EMBOLISM

One condition that might be confused with coronary occlusion is pulmonary embolism, which, according to Towbin[1] may be the commonest cause of death in the aged. The most common cause for pulmonary embolism is thrombosis of the peripheral systemic veins, due to infection in the lower extremities, fractures of the femur, surgery, or long enforced bed rest, in the presence of circulatory embarrassment of the lungs as in congestive cardiac failure and infection. These tend to the formation of peripheral venous thrombosis, and detachment of the thrombus results in pulmonary embolus. The history, physical signs, roentgenogram, and electrocardiogram (wide S, short ST segment, and Q3s3) will often help to differentiate this from coronary occlusion.

DISSECTING ANEURISM

Frequently one encounters great difficulties in distinguishing the dissecting aneurysm syndrome from other catastrophic illness, particularly acute myocardial infarction. Symptoms depend on the extent of aortic dissection and the particular branches involved. The usual history is of sudden onset of tearing and crushing substernal pain, frequently radiating to back of neck, shoulders, or epigastrium. Antecedent hypertension is common and the blood pressure level is usually maintained during the acute episode, in contrast to acute myocardial infarction where the blood pressure drops. Baer, however, states that a history of pain was not obtainable in about 50 per cent of his series.

The protean manifestations of this disease depend upon the length of time the patient survives, the extent of the dissection, and the branches of the aorta involved. Thus we may have inequalities in blood pressure or pulse in branches of the inominate, carotid, or iliac arteries. Hemiplegia, renal infarction, or mesenteric vascular occlusion may occur. Bizarre neurological complaints or findings, including paresthesias of the extremities, may occur, secondary to the shearing off of intercostal or lumbar nutrient arteries to the spinal cord by the process of dissection.[5] In the Moersch and Sayre series of 26 cases, 46 per cent showed some neurologic complications.

The frequent occurrence of aortic insufficiency following widening of the aortic commisures by the dissection is often helpful in the diagnosis. Logue et al.[5] presented a new sign in dissecting aneurysm, viz.: pulsations of either right or left sternoclavicular joint, which may be vigorous or minimal. This sign depends on the sudden fluctuating increase in superior mediastinal pressure resulting from acute expansion of the aorta. This sign, they state, is not found in association with chronic enlargement of the aorta occurring in hypertension.

The presence of a basal diastolic murmur may cause confusion in the differentiation of aortic insufficiency due to hypertension with a dilated aorta, from that due to dissecting aneurysm. The presence of a pulsating sternoclavicular joint with aortic insufficiency, hypertension, and a dilated aorta, has proved diagnostic of dissecting aneurysm, and does not occur in uncomplicated hypertension. The protean manifestation of this disease, when present, may suggest its diagnosis.[5] Syphilitic aortic insufficiency can likewise be ruled out by absence of pulsating sternoclavicular joint. Large aneurysm of the aorta is usually obvious from roentgenogram of the chest. Small ones as a rule give no symptoms.

MISCELLANEOUS CAUSES OF CHEST PAIN

Tumors of the lung may lead to chest pain either by direct pressure or by bronchial occlusion followed by atelectasis and infection.[1] Sudden massive atelectasis from any cause is likely to be associated with thoracic pain. Other possible causes of this symptom are subphrenic abscess, benign or malignant tumors, pulmonary congestion, broncholiths, air embolism, arteriovenous fistula, interstitial emphysema, bronchospasm with retention of fluid. In many of these instances pain is exaggerated on deep inspiration or on coughing. In lung tumor the pain may radiate to the arm; there may be cough or hemoptysis. The history, physical examination, roentgenogram, and bronchoscopy will usually clarify the diagnosis. In some instances sputum and cytology examinations may be helpful.

Pleurodynia may occasionally be mistaken for coronary occlusion. Fortunately this malady is not common, and in an epidemic form it is easily recognized. However, in the early stages and in a sporadic case it may offer some difficulty. The following signs and symptoms may suggest it: In this condition the patient often complains, "I can't breathe," or "It hurts to breathe." The pain usually shifts from side to side and is aggravated by movements of breathing, and may be so severe that the patient splints his chest by holding arm tightly against chest. There may be moderate tenderness in the affected area with hyperesthesia and localized muscle swelling. The electrocardiogram does not show the changes usually found in coronary occlusion.

Almost any mediastinal disease may cause retrosternal pain. This includes mediastinitis, enlarged hilar and paratracheal lymph nodes

caused by tuberculosis, fungus disease, generalized infection, sarcoidosis, infectious mononucleosis, syphilis, silicosis, and disease of the hemopoietic system. The tumors may be malignant or benign, intrathoracic nodular goiter, mediastinal cyst, hernia, and perforation of the esophagus by a foreign body. The pain in these conditions may be anginoid in character. Pneumomediastinitis is likely to cause considerable chest pain together with dyspnea.[1]

In most of these cases x-ray of the chest is of greatest help in arriving at a diagnosis. Of course, the history and complete physical examination must not be overlooked, and special examinations like sputum, blood, and even biopsy may be resorted to in some of these cases.

ESOPHAGUS

Affection of the esophagus with or without dysphagia is the source of thoracic pain more frequently than generally realized,[1] and the discomfort varies from mild to severe pain anteriorly and posteriorly. It may be localized in midline or laterally. In some instances it is identical with anginal pain. The cause of the pain may be cancer or other tumors, foreign body, rupture, strictures, diverticulum. Anginoid pain may result from esophageal spasm. Hiatus hernia as a possible cause of chest pain is often overlooked, and the pain may be angina-like or localized at the lower part of the chest, left costal region, or in the scapular region. It is worse when the patient lies down and is relieved by sitting up or walking around. Diagnosis is established in the above by x-ray with contrast medium, and occasionally esophagoscopy may be resorted to. The history of dysphagia will usually direct attention to the esophagus.

PLEURISY

In pleurisy, the site of pain usually coincides with the site of maximum involvement. Patients with diaphragmatic pleurisy may complain of pain in the shoulder region because of the transmission of impulses from the sensory receptor nerves of the phrenic nerve to the cervical cord and from there to neck and shoulders. In diagnosis of pleurisy it is well not to rely on roentgenography alone. Pronounced friction sounds may be audible in some cases of pleurisy without demonstrable change in the x-ray film.[1] Small pleural effusions may not be seen unless the patient is lying on the involved side.

Thoracic pain originating from the pleura may be caused by infarction, primary and metastatic neoplasms, hemopneumothorax, chylothorax, trauma, and formation of bronchial fistula. In spontaneous pneumothorax and in tumors of the pleura pain may be precordial and angina-like. Also in some cases of pneumonia and lung abscess the pain may be retrosternal.[1] But these conditions lend themselves to a diagnosis if we employ all the laboratory tests (bacterial, chemical, cytology, x-ray) and the physical signs.

PERICARDITIS

Nonspecific benign pericarditis. Pain is the most consistent symptom of pericarditis. It is present in practically 100 per cent of the cases.[6] The character of the pain varies from patient to patient, and from day to day. The pain is described as sharp and knife-like, crushing, or dull. The pain is located over the lower two-thirds of the sternum and lateral to the sternal margins. It may radiate to the left shoulder but rarely to the left arm. Accompanying the pain is a severe deep substernal soreness. Both pain and soreness are aggravated by respiration, cough, and physical movements of the chest. This aggravation is **not** characteristic of pain associated with coronary thrombosis.

Symptoms of cold, sore throat, or influenza-like infection usually precede the onset of pain. Pericardial friction may be heard early in the onset of the illness. Roentgenogram shows obvious increase in heart size due to more or less pericardial effusion. Electrocardiogram changes are characteristic. Initially there is an elevation of ST with upright T waves. This may persist for several days to a week or more, and the T waves become inverted. Q waves are absent and there is no reciprocal depression of the ST segments. This type of pericarditis is advisedly called nonspecific benign, in contrast to the specific types, tuberculous and rheumatic.

In *tuberculous pericarditis* the effusion is large in amount and recurs after aspiration; pain is conspicuously absent, and studies on the aspirated fluid may be helpful. In *rheumatic fever*, pericarditis is a part of pancarditis. In the nonspecific benign pericarditis the disease is primary, tends to recovery, the effusion subsides spontaneously or does not recur after aspiration.[6] All these factors will help to differentiate this from angina pectoris or coronary occlusion. Pericarditis may also occur as a complication of pneumonia, septicemia, or uremia, but the primary disease can be demonstrated.

CHEST WALL DISEASES

A great many diseases of the chest wall may be mistaken for cardiovascular affections. In this category belong myositis, fibrositis and disease of the spinous ligaments, osteomyelitis, periostitis, and tumors of or fractures of the cervical or thoracic vertebrae, the ribs, the sternum, and Tietze's syndrome. In the latter condition, according to Prinzmetal, pain and tenderness are limited to the costal cartilages and the superadjacent tissue: the cartilages most commonly involved are those of the second ribs. There may be visible hypertrophy and tumefaction of those cartilages. It differs from intercostal neuralgia by its limited location and by

the absence of sensory changes along the course of the nerves.

The differential diagnosis in the foregoing can be made, and I repeat, by a good history; complete physical examination, emphasizing the presence or absence of localized disturbances; pain not precipitated by physical or emotional strain although it may be aggravated by them; and lastly, by a consideration of all of the above possibilities. I recall a patient who called me recently. "Doctor," he said, "come at once. I am having a heart attack." When I got to the house and took one glance at his chest, the diagnosis stared me in the face. He had a typical case of herpes zoster over the left chest. If I had seen him prior to the appearance of the vesicles, I would have had to consider angina pectoris in my differential diagnosis.

Neurocirculatory asthenia (effort syndrome, irritable heart). This is a functional disorder of the vasomotor system characterized by dyspnea, palpitation, precordial pain or discomfort, easy exhaustion, faintness too readily induced by effort or excitement or even coming on at rest without evidence of lung, heart, or brain disease. Dizzy spells, tinnitus, insomnia, and nervousness may also occur. Nitroglycerin gives little or no relief. In a group of asthenic subjects studied by Master the electrocardiogram showed a tendency toward right axis deviation.

ABDOMEN

Chest pain originating from some of the abdominal organs is well known. Substernal pain simulating angina pectoris may be noted in gallbladder disease. In some cases acute gastritis, peptic ulcer (penetrating), distension of stomach due to aerophagia may produce precordial pain. Precordial pain may also result from pylorospasm and severe gastric optosis. In some of these instances it may be referred to the neck, shoulder, and arm. Pain below the right scapula or in the right shoulder is a common occurrence in cholecystitis. Pancreatitis and cancer of the pancreas, sudden hepatomegaly due to congestive cardiac failure may cause pain in the lower chest or in the shoulder.[1]

But in all these conditions there is usually some lead to the site of the trouble: localized tenderness, time table in relation to food. X-ray, and other laboratory tests should render the diagnosis not difficult except in a rare case when even the expert may have to summon all his ingenuity to make a diagnosis. As a general rule, when symptoms and findings are incompatible, then the emphasis should be placed on the former rather than on the latter.

Accurate diagnosis is the key to successful treatment in chest disease as in all other diseases. But that may not always be easy. Sometimes it may baffle the expert. However, if one takes a careful history, considers all the possibilities, and employs the diagnostic means, physical signs, laboratory tests, roentgenogram, electrocardiogram, biopsy, bronchography, skin tests, cardiorespiratory function tests as the occasion may require, one will usually be rewarded with an accurate diagnosis. This is the goal of every good physician, and the greater the difficulty, the greater the gratification.

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KEEPING UP WITH MEDICINE

• CANCER of the breast, in most western countries, is twice as frequent as any other type. The disease is surprisingly infrequent, however, in societies where marriage is early, children numerous, and breast-feeding customary.

* * *

• SERUM VIRAL HEPATITIS, induced by the physician, is characterized by remarkably long incubation.

* * *

• STRESS INCONTINENCE is preventable and is reversible at any time in life. Even when associated with systemic disease, it is influenced by muscle education and resistive exercise, especially in the early stages. Physiologic therapy, therefore, is indicated at the first sign of weak control of the bladder, regardless of cause.

* * *

• NEWER EVIDENCE that satisfactory growth can be obtained on far lower protein intakes than has been deemed possible, opens up possibilities of supplemental diets in underdeveloped countries with materials which are cheap and therefore practical.

* * *

• IN SENILE EMPHYSEMA the primary defect appears to be a structural alteration in the thoracic cage due to degeneration of the intervertebral cartillaginous disks producing a postural deformity characterized by kyphosis and an increased anterior-posterior diameter.

* * *

• HYPOTHYROIDISM does not occur in the allergic child any more often than in children generally. The malnourished, asthmatic child often responds to the exhibit of thyroid in small stimulating doses. The eczematous child, too, often will not respond to anti-allergic management unless thyroid medication is undertaken at the same time.—J. F.

Problems in the Management of Bladder Neck Obstruction in Children

EDGAR BURNS, M.D., and PAUL SHASHY, M.D.

IN the management of obstructive lesions of the lower urinary tract in children we have been impressed by the amount of damage to the upper urinary tract that has occurred in the majority of cases when the condition is first recognized. A review of the findings in 110 private patients with non-neurogenic obstruction treated surgically indicates that the majority of the problems encountered result from delayed recognition. This delay is apparently due to failure to consider the possibility of an obstructive lesion in children who have abnormalities in the voiding pattern.

The Authors

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SYMPTOMATOLOGY

It has been repeatedly stated in the literature that symptoms of bladder neck obstruction in children are in many cases unfortunately meager. It would perhaps be more accurate to state, and certainly safer from the standpoint of the child, that obstructive lesions of clinical importance in children, as in all age groups, are symptomatic but that they are too often not assessed at their proper value.

In the cases reviewed the following symptoms were recorded: frequency and straining to urinate, enuresis, fever of unexplained origin, recurrent or persistent pyuria, urgency, overflow incontinence, acute retention and hematuria. Frequency and straining to urinate are early symptoms, and if the obstruction is severe, they should be observed during the first year of life, not infrequently during the first six months.

The difficulty in recognizing urinary symptoms during infancy is understandable. It should be emphasized that during this period fretfulness and crying are the baby's only means of expressing discomfort, and abnormalities in voiding therefore must be detected chiefly on the basis of objective signs rather than subjective evidence. Wetting the diaper at abnormally frequent intervals may be noted and straining to urinate is often indicated by a purplish discoloration of the face during the voiding act. These are signs that warrant investigation of the urinary tract.

Prompt studies that are made upon the basis of minimal signs or symptoms will always be rewarding. The majority of these will show a normal urinary tract but if an obstructive lesion is found, it is usually during a period when early and uncomplicated recovery can follow removal of the obstruction. The importance of this is emphasized by the following cases in which frequency and straining on urination were observed during infancy:

Presented before the Section on Urology at the Annual Meeting of the Ohio State Medical Association in Cleveland, April 12, 1956.

CASE REPORTS

Case 1: A male child, aged 27 months, was admitted to the hospital in a comatose condition. Frequency and straining had been noted by the grandmother when the infant was three months old. This was attributed to a redundant phimotic foreskin and circumcision was performed. At the age of 15 months the child had had the first episode of chills and fever, which was thought to originate elsewhere than in the urinary tract. An abdominal mass was first felt a few days before admission to the hospital and the referral diagnosis was abdominal tumor. Upon catheterization of the bladder the abdominal mass disappeared. The urologic studies, which were performed two years after onset of symptoms, revealed dilated tortuous ureters and kidneys in terminal failure.

Case 2: A male child, was first seen at the age of three months. Frequency and straining had been noted by the mother since birth. Urologic studies revealed a severely decompensated upper urinary tract. This case illustrates that renal damage may occur early, and obviously this child's urinary tract was dilated at birth. It also places emphasis upon the importance of prompt investigation. The bladder neck obstruction was removed and suprapubic drainage was continued because of pronounced dilatation of the upper urinary tract. Tortuosity in both upper ureters prevented unobstructed passage of urine to the bladder and these were resected. This child still has a dilated upper urinary tract now at the age of 5 years.

Case 3: (Fig. 1) An adopted baby girl, was first seen at the age of one year. The pediatrician who examined her for the adoption agency considered her to be healthy from every standpoint. She had been adopted at the age of 9 months. It was first noted that she wet the diaper at intervals of 30 minutes to one hour. She later had an episode of chills and fever, and pus found in the urine directed attention to the urinary tract. Urologic studies showed a severely dilated blad-

der with vesical ureteral reflux. After removal of the bladder neck obstruction, the right side of the urinary tract returned to normal. Reimplanation of the left ureter, however, was later performed because of continued vesical ureteral reflux and increasing hydronephrosis.

This case emphasizes the importance of giving consideration to functional disturbances in the urinary tract equal to that accorded gastroin-



Fig. 1. Retrograde cystogram showing dilated bladder with bilateral ureteral reflux in female aged one year—(Case 3).

testinal disturbances, such as vomiting, diarrhea or any of the other common pediatric problems. It also emphasizes the importance of including urologic studies in the general examination of children who are to be adopted.

In the absence of infection, frequency may be the only symptom for a long period. An example of this type is that of a boy who was first seen at the age of 10 years. He had a history of nocturia seven or eight times with corresponding frequency during the day. The fact that the urine had not become infected perhaps accounted for absence of other symptoms that might have led to earlier study of the urinary tract. He was found to have 1000 cc. residual urine with bilateral ureteral reflux and advanced hydronephrosis. Constant suprapubic drainage was continued for one year after the bladder neck obstruction had been removed and now, six years later, he has a sterile urine and empties the bladder completely but the renal damage is permanent.

Enuresis is the most common urinary disturbance in children. It is considered functional in the majority of cases and urologic investigation on the basis of enuresis alone is not usually carried out in children under the age of four years. The chief reason for this is that many children do not stop wetting the bed before, or even after that age. Medical treatment and psychotherapy are frequently carried out for a long time before attention is directed to the urinary tract.

In a reported series 12 per cent of those investigated for enuresis were found to have organic disease producing vesical irritability.[1] Slightly more than 28 per cent of those examined on our service had some type of obstructive lesion of the lower urinary tract. On the basis of these figures it appears that a safe course to follow would be to consider enuresis as a symptom of possible urologic disease rather than a functional disturbance.

The ease and safety with which urologic studies can be carried out in children have largely removed objections to such examinations. Recognition of those in the enuretic group who have organic disease during the period when the urinary tract may be restored to normal would certainly seem to justify the study.

Unfortunately, urologic studies for enuresis are frequently delayed until the child is old enough to be embarrassed by wetting the bed while visiting a friend. An example of this type is that of a 7 year old girl (Fig. 2), whose only urologic

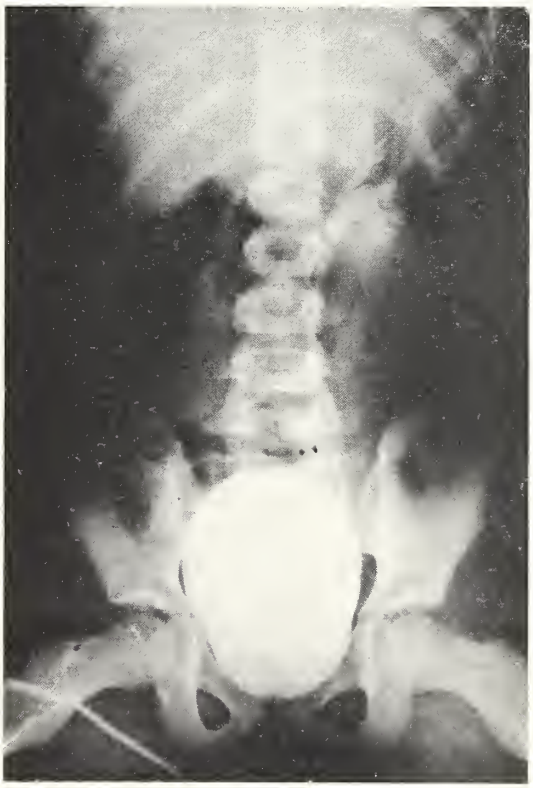


Fig. 2. Retrograde cystogram of a 7 year old girl, whose only symptom was enuresis.

symptom was enuresis, which had existed since infancy. She had had all the usual types of treatment of enuresis without benefit. Urologic studies showed bladder neck obstruction with left vesical ureteral reflux. Her symptoms were relieved by removal of the obstruction.

Wetting of the clothing during the day is rare in the absence of urologic disease. Eighteen per cent of our patients had this symptom and all had infected urine, residual urine, or both. An example of this type is that of a patient (Fig. 3),

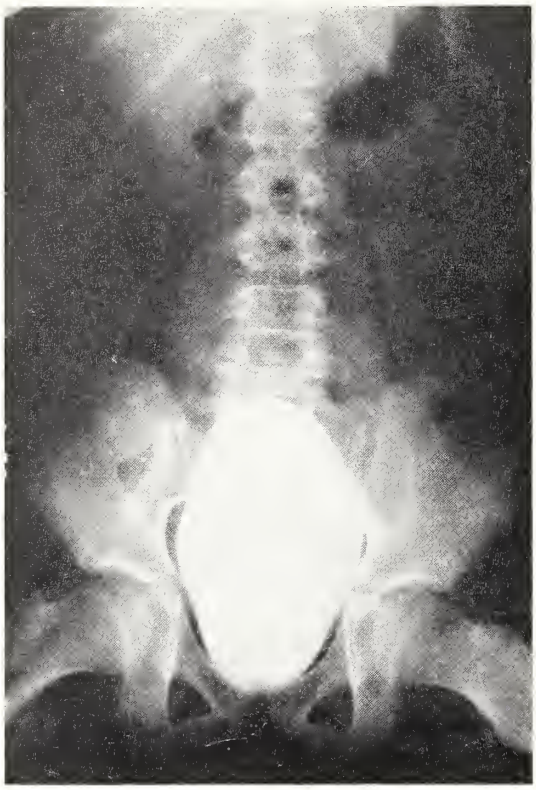


Fig. 3. Retrograde cystogram of a girl aged 9 years, without the usual dilatation of the bladder seen accompanying bladder neck obstruction in children.

aged 9 years, who had had recurrent attacks of chills and fever with pus in the urine since the age of 3 years. She had had enuresis all her life and during the preceding two years had wet her clothing during the day as well.

Examination showed pronounced elevation of the posterior internal vesical area and trabeculation of the bladder similar to that seen in men with prostatism. In this case the severe dilatation above the obstruction frequently seen in children was not observed; for that reason careful neurologic studies were carried out in order to rule out a neurologic lesion as a possible cause of the symptoms. The importance of this needs no emphasis.

The amount of residual urine in the majority of cases is not large, often not more than 2 or 3 ounces, and therefore does not constitute an index as to the amount of dilatation the urinary tract may have suffered. Acute retention of urine requiring catheterization occurs less frequently from bladder neck obstruction in children than from obstruction in adults. The child's bladder has a tendency to undergo pronounced dilatation and become nothing more than a large atonic sac. Overflow incontinence in these cases will be observed more often than inability to urinate. Acute retention was observed in only four of our 110 patients.

HEMATURIA

Gross hematuria is also not a common symptom, having been noted in only two of the 110 cases reviewed. It may result from straining to urinate. Pain in the renal areas may be felt in children with ureteral reflux if they are old enough to localize discomfort. If the ureters have become sufficiently dilated to cause reflux, they no longer act as protective buffers to the kidneys. In such cases the renal pelves become distended along with the bladder, and the discomfort in the renal areas is exaggerated when the intravesical pressure is increased during the act of voiding. The renal cortex becomes progressively atrophied in these cases, and when the kidneys become infected, renal failure progresses at a more rapid rate.

PYURIA

In the patients who have come under our care, as well as those cases reported from other medical centers, pus in the urine was the finding that led to investigation of the urinary tract in the majority of cases. It should be emphasized that infection is a complication of obstruction, frequently a late one, and the fact that pus in the urine constituted the first indication for urinary tract studies is an indication that earlier symptoms were overlooked or considered insignificant. Pus was found in the urine of 76 per cent of our patients on first examination, and 85 per cent of these had suffered recurrent attacks of chills and fever.

That there are other causes of infection in the urinary tract aside from obstructive lesions is well known, and the importance of differentiating the various causes needs no emphasis. The custom a few years ago of examining the urinary tract of children after their third attack of urinary infection is no longer observed. Complete study of the urinary tract is indicated just as much the first time pus is found in the urine as it is in subsequent recurrences. No child should be treated for recurrent pyelitis without first determining whether or not it is a complication of an obstructive lesion. The complications that arise from failure to observe this principle may be far reaching.

An example of this type is the case of a 5 year old girl, who was admitted to the hospital following a cerebrovascular accident. She had been treated for recurrent urinary infection over a

period of three years. The urinary infection was considered nothing more than the ordinary type of pyelitis of childhood. Examination revealed a blood pressure of 230 mm. Hg. systolic and 120 mm. Hg. diastolic. Investigation of the urinary tract showed the infection to be a complication of bladder neck obstruction. As a result of the chronic pyelonephritis, an atrophic kidney developed on the right side which was thought to be the cause of the hypertension (Fig 4).

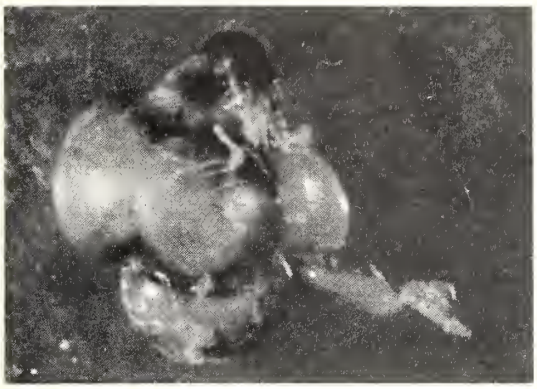


Fig. 4. Photograph of atrophic right kidney from long-standing pyelonephritis (Case of a 5 year old girl).

TYPES OF LESIONS

There are three types of obstructive lesions found at the neck of the bladder in children: (1) contracture of the internal sphincteric area, (2) congenital prostatic valves, and (3) congenital hypertrophy of the verumontanum. Contracture of the internal vesical orifice, which occurs with equal frequency in males and females, accounts for the majority of cases of obstruction. It was found in 101 of our 110 cases.

Congenital prostatic valves as the cause of bladder neck obstruction in children has been overemphasized in the literature, so much so, that until the past few years it was considered the most common cause and led to the impression that congenital bladder neck obstruction in children occurred chiefly in males. Prostatic valves were found in only three of our 110 cases. Mucosal folds have been reported to be of sufficient size to cause bladder neck obstruction in females but this was not recognized in any of our cases.

Congenital hypertrophy of the verumontanum is also a rare cause of bladder neck obstruction and was found in only two of our cases. As the hypertrophy progresses the verumontanum elongates and may rest at the internal vesical orifice presenting a miniature version of a middle lobe prostate in the adult male.

Another lesion that may cause bladder neck obstruction in children is ureterocele. Although not involving the bladder neck primarily, it may become large enough to occlude the internal vesical orifice, upon efforts to urinate, especially in the standing position. In females a portion of the ureterocele may be extruded through the external urethral meatus. It accounted for obstruction in three of our patients, two of whom had suffered episodes of acute retention. An example of this is the case of a girl 3 years old (Fig. 5), whose bladder showed the characteristic findings of obstruction.

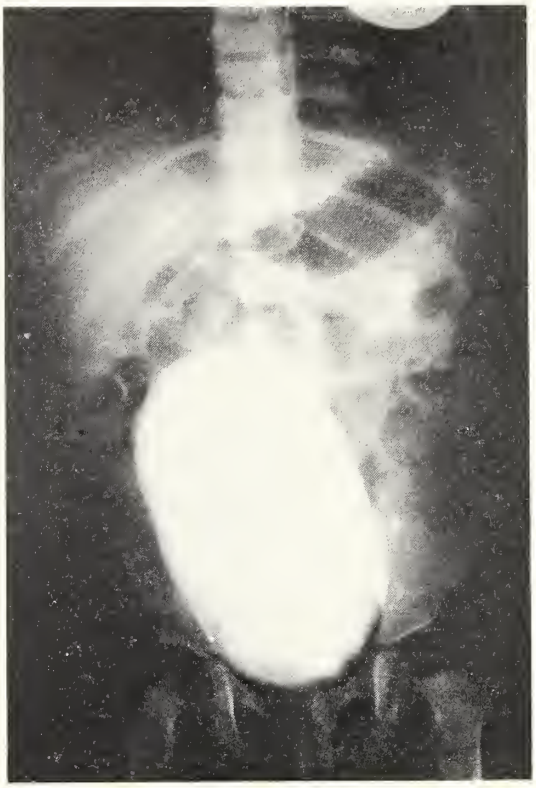


Fig. 5. Retrograde cystogram of a girl aged 3 years, showing bladder neck obstruction from a ureterocele.

Still another congenital obstructive lesion in the lower urinary tract, of equal importance to those at the bladder neck, is stenosis of the external urethral meatus. It is found with equal frequency in both males and females and may be associated with other obstructive lesions. Careful examination of the external urethral meatus should therefore constitute a part of every urologic examination in children.

DIAGNOSIS

The diagnosis of bladder neck obstruction in children is easily accomplished. Specific studies include chemical and bacteriologic examinations of the urine, renal function tests, excretory urograms, retrograde cystograms, cysto-urethroscopic examinations and retrograde pyelo-ureterograms as individually indicated.

If infection is present, it is important to identify the specific organism in order to permit more appropriate selection of drugs for treatment. Estimation of renal function is obtained

by tests of both excretion and retention. This is important from the standpoint of outlining treatment as well as determining prognosis.

ROENTGENOGRAPHIC STUDIES

The excretory urogram will provide additional information regarding renal function, and in many cases, will indicate variations from the normal that may be produced by an obstructive lesion. It is also of value in suggesting the presence of associated anomalies of the urinary tract. This examination may be performed with use of either intravenous or intramuscular injection. If intramuscular injection is used, hyaluronidase should be added in order to hasten absorption.

In our experience retrograde cystography has provided more information than any other urographic studies. The location of the obstruction can usually be determined, that is, whether it is at the internal vesical orifice from contracture or at the apex of the prostate from valves, or whether there is a filling defect that may be produced by hypertrophy of the verumontanum. The cystogram will also demonstrate any changes that have occurred above the point of obstruction and the presence or absence of vesical ureteral reflux. The usual finding is a large flaccid bladder, either with or without ureteral reflux. Bladder diverticulum due to bladder neck obstruction is not encountered as often in children as in adults. It was found in only two of our cases.

In those patients who have ureteral reflux not only is the transverse diameter of the ureter increased but the ureter is elongated and tortuous. In such cases it is important to determine whether or not the tortuosity produces obstruction to the passage of urine from the kidneys to the bladder. This can be determined by an evacuation film, which will show whether or not the kidneys empty along with the bladder. This is important from the standpoint of treatment since all back pressure upon the kidneys must be relieved in order to preserve renal function.

Any one of several contrast media may be used in making the cystogram. It is our custom to use a 2.5 per cent solution of sodium iodide, which is nonirritating and casts an adequate shadow. The bladder is filled by gravity from the barrel of a 2 ounce Triumph syringe held only the length of the catheter above body level. The medium should never be forcefully injected. A voiding cystogram in children who are old enough to cooperate may show ureteral reflux not demonstrated in the gravity film.

A ten, twenty or thirty minute delayed film may bring out the same finding. Reflux that can be demonstrated only in this manner is of questionable significance. In the majority of cases cystoscopic studies serve only to confirm the urographic observations. Retrograde pyelo-ureterograms are rarely indicated but may be necessary to obtain accurate evaluation of the upper urinary tract.

Obviously, all instrumental studies in children should be done with use of an anesthetic. For some time we have been using sodium pentothal® rectally supplemented by nitrous oxide. In many infants and younger children pentothal® alone has been found to provide sufficient anesthesia to carry out the indicated studies.

In the evaluation of the results of the diagnostic studies it is important to recognize associated lesions, as some of these require operative treatment along with the bladder neck obstruction. Ureterovesical junction obstruction, ureteropelvic obstruction, fused kidneys, hypoplastic kidney, atrophic pyelonephritis, and congenital solitary kidney are associated lesions that we have encountered in our series. The frequent association of obstructive lesions of the urinary tract with genital anomalies, such as hypospadias or undescended testes, as well as developmental defects that occur in other systems, has emphasized the importance of performance of studies of the urinary tract in all such cases.

TREATMENT

The treatment of obstructions of the lower urinary tract in children is surgical removal of the primary lesion. There are two methods by which this can be accomplished: (1) transurethral resection, and (2) suprapubic transvesical approach. The method used should accomplish complete removal of all obstructing tissue. Additional methods to correct secondary complications are utilized as individually indicated.

Transurethral resection may be adequate for removal of obstruction in older children. In males performance of a perineal urethrostomy will permit use of a larger instrument and to some extent eliminate some of the risk of postoperative urethral stricture, a common complication following transurethral resection in all age groups. The obstructive lesion in these cases is never large and transurethral resection is easily carried out but not infrequently repeated operations have to be done.

In infants and younger children, especially males, the urethra is too small to permit an instrument of sufficient size to provide good vision and to carry an adequate working element for removal of the obstruction. In this group the suprapubic transvesical approach will be found much easier to perform. It is usually a one stage procedure and is followed by a more satisfactory end result. In children the bladder neck occupies a higher position in the pelvis than it does in adults, thereby affording easy access for exposure of the obstructed area. The usual procedure is to remove a wedge from the posterior internal vesical orifice. In the case of prostatic valves these can be easily exposed and removed through the same approach.

In 1953 Young[2] described a supplementary pro-

cedure which in our experience has proved most valuable. In addition to the wedge resection a longitudinal incision is carried through the internal sphincteric area into the anterior capsule and closure is affected in a transverse manner. This provides perceptible enlargement of the bladder neck in addition to that accomplished by wedge resection alone.

ASSOCIATED URETERAL REFLUX

In the management of patients who have ureteral reflux, decision has to be made between (1) simple removal of the bladder neck obstruction, (2) removal of the obstruction and reimplantation of the ureters, and (3) removal of the obstruction followed by prolonged drainage either by a suprapubic cystostomy tube or by an indwelling urethral catheter. In those patients who have early dilatation of the upper urinary tract, removal of the obstruction alone has been followed by return to normal within a period of three to six months. Interval examination of this group is important in order to be certain that improvement is satisfactory.

In other cases the period of reflux will be shortened if the ureters are severed at their entrance to the bladder and are reimplanted. This can be done at the same time the bladder neck obstruction is removed. Selection of the cases to be treated in this manner is a matter of judgment.

In still other patients, especially those who have a greatly decompensated upper urinary tract, prolonged drainage will be required in order to provide the maximum opportunity for the upper urinary tract to return to normal. Indwelling urethral catheters can be worn with comfort and without complication in females. A short female type of Foley catheter is used and attached to a four ounce collecting bag. In males, however, if there is necessity for prolonged catheter drainage, suprapubic cystostomy is required because of the tendency to development of peri-urethral abscesses.

Patients who have dilated tortuous ureters that produce obstruction to the kidneys will require resection of the obstructed areas and reanastomosis. Associated obstructive lesions of the upper urinary tract will require treatment as indicated in the individual case. Ureterovesical junction obstructions can be operated upon at the same time that the bladder neck obstruction is removed. Lesions above this level have to be corrected at a separate operation.

Attempts to treat bladder neck obstruction in children by urethral dilatation have in our experience not been successful. The dilatations require some type of anesthesia and have to be done at too frequent intervals to be practical. Contracture of the internal vesical orifice, which constitutes the large majority of these obstructions, consists of fibromuscular tissue and therefore could not be expected to show any particular response to dilatation.

The installment emptying of the bladder advised in the past in some cases and still appearing in some of the current textbooks should be relegated to the museum of antiquated methods. By this method the patient urinates as much as he can, waits 15 to 30 minutes, and urinates again. This procedure is repeated until no more desire to urinate is felt. Such treatment can only contribute to irreversible renal failure if carried out for a long enough period.

SUMMARY

Failure to consider the possibility of an obstructive lesion at the bladder neck in children who have abnormalities in the voiding pattern has resulted in permanent damage to the upper urinary tract which could have been avoided by proper treatment before the damage became irreversible. Probably one reason for this delay is the fact that this lesion sometimes causes such meager symptoms in children that they are too often considered of no importance. Among symptoms that have been noted in our patients are frequency and straining to urinate, enuresis, fever of undetermined origin, recurrent or persistent pyuria, urgency, overflow incontinence, acute retention and hematuria. Any of these symptoms is an indication for prompt study of the urinary tract.

Three types of obstructive lesions at the neck of the bladder are encountered in children. The commonest type is contracture of the internal sphincteric area. Congenital prostatic valves were formerly thought to be common but are now considered almost as rare as congenital hypertrophy of the verumontanum, as a cause of obstruction of the bladder neck in children. Ureterocele and stenosis of the external urethral meatus are other possible obstructive lesions of the bladder neck in children.

The condition is not difficult to diagnose. Specific studies which should be undertaken are chemical and bacteriologic examinations of the urine, renal function tests, cysto-urethroscopic examination and roentgenographic examinations including excretory urograms, retrograde cystograms and retrograde pyelo-ureterograms as individually indicated.

Treatment consists in surgical removal of the primary lesion, either by transurethral resection or suprapubic transvesical excision. Associated lesions or secondary complications should also be corrected surgically when necessary.

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The Amphetamines and the Sleepy Driver

CHAUNCEY D. LEAKE, Ph.D.

THE problem of the sleepy driver has recently been well discussed by J. R. Rodger. Here is an increasingly important subject, which practicing physicians may help to solve. It is a matter that is likely to become more serious, as more auto and truck travel gets on the road. The National Safety Council estimates 4.3 per cent of the total number of fatal accidents are caused by driver fatigue, or going to sleep at the wheel. Roughly this means that in 1955 there were some 1,500 deaths, and 53,000 injuries attributable to sleepy automobile and truck drivers.

With 50 per cent increase in automobile and truck mileage in the next 10 years, it will be necessary to reduce the accident rate on the highways by 50 per cent, in order to keep it where it now is. Everyone realizes that the accident rate is too high, and that everything should be done to attempt to reduce it.

Many factors can aid in reducing highway accidents. These will include better highways, improved car design, getting alcohol out of driving, better driver education, and more alertness and attentiveness on the part of drivers. The prevention of traffic accidents is not so much a matter of law enforcement as it is of better driving. While there is much attention being given to safety belts, and crash rubber for dash boards, improved car design might also consider the proposition of rubber bumpers and fenders, and rubber mud guards. These could be plasticized and thus be given that shiny look that Americans seem to think necessary for a good car. However, the most important factor in reducing traffic accidents will be the care and alertness of the driver. Here it is essential that all automobile and truck drivers learn to handle themselves with discretion, particularly with regard to alcohol and sleepiness.

Rodger suggests that physicians are in a peculiarly strategic position to advise about care and sleepiness in driving. Certainly physicians can drill into all patients that under no circumstances should they drive if they have had anything alcoholic to drink. Alcohol is well known to slow reaction time, to interfere with judgment, and to give muscle relaxation. These effects can be produced by very small amounts of alcohol. Unfortunately, these effects are not subjectively realized. There must be then appreciation of an inflexible rule: not to drive if anything alcoholic has been drunk—if you drink don't drive; if you drive don't drink!

More careful advice is necessary in connection with handling fatigue and sleepiness. Many patients will complain to physicians regarding stiffness, radiating leg pains, sleepiness and fatigue, in association with driving. Here it is that the wise physician may help greatly in advice on care and alertness in respect to driving.

When patients complain in any way regarding symptoms observed when driving, it will be wise for a general physical examination to be given, in order to determine as carefully as possible what may be the cause of the complaint. Radiating leg pains may refer to low back pain, to spasm of back muscles, or to unsatisfactory posture. Abnormal fatigue or sleepiness may suggest unsatisfactory diet, endocrine disorder, or neuromuscular disorder. Various cardiovascular factors may be involved in some of these matters. In examinations under these circumstances it might be helpful to be sure that vision and hearing are satisfactory.

When it is a matter of just plain sleepiness or fatigue, the physician may have an opportunity for effective counseling and guidance.

It may help for physicians to suggest careful attention to rest periods, to avoid hazardous driving or excessively long driving periods, to avoid thinking over problems or engaging in serious conversation while driving, and to focus attention as far as possible on the road and on the performance of the vehicle.

DRUGS AGAINST FATIGUE

Drugs may be used cautiously in connection with the sleepy or fatigued driver. Most everyone has learned by long trial the amounts of coffee which may be helpful in promoting wakefulness and alertness. Caffeine acts fairly quickly, is eliminated fairly rapidly, and its effect generally is rather fleeting. Nevertheless, it does cause direct central nervous system stimulation, with increased alertness, and with facilitation of interneuron nerve transmission. It has some slight effect peripherally on muscles, in reducing the onset of fatigue. Nevertheless, caffeine has some disadvantages. It is a diuretic, it may produce nervousness and insomnia, and on long re-

Submitted November 13, 1956.

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peated use, its effects as a stimulant may become relatively slight.

For selected patients, sensible doses of the amphetamines may be recommended. There has been much popular apprehension recently regarding the use of the amphetamines by truck drivers. Over hasty and ill-advised publicity regarding the possible dangers of the amphetamines for truck drivers has sharpened interest in the problem. Unfortunately, exaggerated statements have been made, indicating that the amphetamines contribute to irresponsibility, confusion, and delirium. This is quite unlikely. The amphetamines are central nervous system stimulants, and may cause increased alertness, attentiveness, and excitement. There is no evidence that the amphetamines cause any confusion of mental processes, or that they cause neuromuscular disturbances, or mental phenomena that may be classified as delirious.

The amphetamines are rapidly absorbed and distributed when taken by mouth. They seem also to be fairly rapidly excreted in the urine, and usually without much change. Over many years' experience, their use has been well standardized with respect to promoting wakefulness and alertness, relieving fatigue, and preventing sleepiness. Even on long, continued, and repeated use there has been no significant report of untoward or toxic reaction.

Amphetamine sulphate (benzedrine®) was introduced by Gordon A. Alles of Los Angeles in 1927. He noted its stimulating effect on the central nervous system, as well as its general sympathomimetic action. Since that time many hundreds of scientific and clinical articles have been reported on amphetamine, covering all aspects of its action and use. Its powerful effect in narcolepsy was noted in 1935 by Myron Prinzmetal of Los Angeles.

Amphetamine came into wide use during World War II, when British troops were supplied with "energy tablets" which were simply amphetamine, for use in fatigue, to prevent sleep, and to maintain action under long periods of stress. There was considerable resistance against the use of amphetamine for U. S. troops, but both flyers and ground fighters of the U. S. Armed Forces bootlegged supplies and used the drug on their own.

The official report of the British workers was: "As the result of extensive laboratory and field investigation of the value and limitations of Benzedrine, it has been determined officially that this drug is the most satisfactory of any available in temporarily postponing sleep when the desire for sleep endangers the security of a mission. . . . Properly employed, Benzedrine will give an army a few extra man hours of fighting at the time they are most needed." An official Naval guide stated: "Energy tablets (1) lessen feelings of fatigue and exhaustion, promote alertness, raise the spirits, and prolong the will to 'hang on' and live; (2) prevent sleep." These findings were supported by similar reports from the Germans. German clinicians used methylamphetamine, which was claimed to give central stimulation without untoward side effects.

DEXEDRINE AGAINST SLEEPINESS

Subsequent extensive experimental and clinical studies have shown that the dextro-rotatory isomer is more satisfactory as a central nervous system stimulant, with fewer side actions. This is available under the trade name, dexedrine.® This is a safe and useful drug for reducing sleepiness and fatigue. There is no evidence that long continued use of this drug causes any untoward effect or addiction. It deserves the recommendation of physicians in selected patients, where sleepiness may be a problem in driving.

If this drug is to be prescribed, there should be certain precautions taken; the dosage should be restricted to 5 mg., which will be satisfactory for maintaining wakefulness and alertness for at least two or three hours; it might be wise to have the patient take a trial dose or two before the actual driving is undertaken, so that he may get some idea of what the effects are like; and certainly it should be emphasized that if the driver gets tired in spite of drug therapy, he had better stop and get some sleep.

In a carefully controlled statistical study on 168 male airmen volunteers, Hauty and Payne have recently shown that 5 mg. of d-amphetamine effectively maintains efficiency of judgment and work performance continually for seven hours after administration. They noted superiority of work proficiency over controls which was sustained for the seven hours of work. These findings, made on simulated pursuit tasks involving aircraft instruments and controls, are applicable, one might reasonably expect, to situations confronting automobile and truck drivers on long rides. These results suggest the value of using d-amphetamine in doses of 5 mg. to prevent driving fatigue, and to maintain alertness. It is significant that the effects can last as long as seven hours from a single dose.

It is interesting that the amphetamines directly relieve fatigue in muscles. This can be shown by direct application of the amphetamines in solution to an isolated muscle. In comparison with a control, the isolated muscle will continue to contract and relax fully for a much longer time, under the same stimulus, even in comparison with a muscle treated in the same way with an equal amount of caffeine. The reduction of this sense of fatigue from the muscles themselves may be a helpful factor in promoting wakefulness and alertness.

The whole matter of wakefulness and sleep requires much more investigation than has hitherto been given it. It is remarkable that although we spend about a third of our lives in sleep, we are still quite uncertain as to what the

factors are that produce sleep. It is known that there are changes in the electrical rhythm of the cerebral cortex, that there is increased blood circulation through the brain, and that there is a reduction in the number of proprioceptive impulses coming to the brain. The reduction in bombardment from proprioceptive impulses results from muscular relaxation. This is why deliberate muscle relaxation, with closing out of stimuli from the outside world, will help induce sleep.

It is rather astonishing that prolonged wakefulness will cause no significant change in body chemistry or body metabolism, as far as the most careful diagnostic tests are concerned. Nor will prolonged wakefulness interfere directly with mental ability. On the other hand, prolonged wakefulness will cause a gradual increase in irritability, annoyance, and the various psychological factors that lead to resentment, frustration, and angry explosion.

On very prolonged experimental wakefulness in animals, there has been observed no significant change in functional activity until a sharp breakpoint occurs. This may come with startling suddenness after several days prolonged wakefulness, and may show first in a disturbance in temperature and respiration. This may be followed by a rapid shift in cardiovascular function, and may presently lead to convulsions. If the stimuli producing the prolonged wakefulness are maintained, the animal will die as a result of the convulsions. Postmortem examination in these instances will show marked degenerative changes in the Nissl bodies of the brain stem, in the thyroid, and in the adrenal. If, however, on the first signs of a break on prolonged wakefulness in experimental animals, the animal is given a chance to rest and sleep, recovery seems to be prompt and complete. The amphetamines will safely prolong the possibility of wakefulness for at least 48 hours, without untoward effect.

However, long clinical experience with the amphetamines has certainly justified their use for the prevention of driver fatigue and driver sleepiness. Their use in this regard should be individualized. The subject should be told just what the amphetamines are, how they act, and what they may be expected to do. Gradually then the subject will learn, as a result of experience, what to expect from an amphetamine tablet. Under these circumstances, it may well be that the use of the amphetamines will help in reducing highway and traffic accidents due to fatigue and sleepiness.

SUMMARY

The sleepy automobile or truck driver may become an increasingly serious problem. Effective preventive medicine may be practiced in regard to this matter by careful advice, and by judicious prescribing of caffeine or the amphetamines. Dosages should be kept to a minimum and trial doses should be taken to observe the symptoms. For the amphetamines, 5 mg. tablets every three to four hours may be sufficient for effective results. Examination into the causes of the fatigue or sleepiness may reveal factors that might require definite medical care.

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Etiology of Infantile Colic

The etiology of the ordinary type of infantile colic is not at all well understood. The fine study of Levin and Bell indicates that, in many instances, the crying of infants may be due to an unsatisfied need for oral gratification, or from abdominal pain caused by spasm of intestinal muscles as a part of the picture of the general hypertonicity of the infant. They reported remarkable relief by the use of the pacifier, i. e. allowing the infant to suck on a rubber nipple.

Brackett has suggested that colic may be caused by excessive volume of contents in the terminal ileum due to hypertonicity of the ileocolic sphincter which in some cases may be of congenital origin and suggests treatment by reducing the volume of food. He draws an analogy between spasm of the ileocolic sphincter and pylorospasm.

Like so many diseases of obscure etiology, infantile colic has not escaped the attention of the psychosomaticist. The mother of the infant with colic has been described as tense, anxious and uncertain; one who is inconsistent in her handling of the baby and often rejects him. The psychiatrist's explanation of the reasons for this personality include early rejection of the baby, rivalry with infant or husband, conflicts about accepting the feminine or maternal role, and her dependency needs. Complicating the picture, colicy attacks commonly occur late in the afternoon, perhaps due to fatigue of the infant. As Ruth Bakwin points out, this is the time when the father comes home from work, just when the infant's distress is greatest. At night he may get little sleep because of the crying. It is not difficult to believe that the mother of the colicy infant is tense, anxious, and exhausted. This is transmitted to the infant, who can feel the tenseness of the mother's muscles when she handles the child for feeding or changing clothes, diapers, etc.—Jerome Glaser, M. D., Rochester, N. Y.: *J. M. A. Georgia*, 45:514, December, 1956.

Sominex® Intoxication with Transient Psychosis (Report of One Case)

RUPRECHT H. MAY, M. D., and GEORGE E. VOEGELE, M. D.

SOMINEX® is a drug available on the market without prescription, widely advertised and commonly used as "an aid to sleep." It is pharmacologically a combination of:

Scopolamine Aminoxide HBr.	0.25 mg.
Methapyrilene HCl.	25 mg.
Salicylamide	200 mg.

It is claimed to have "a good level of effectiveness with very little side effect of any significance," and "that the small size of the dose of scopolamine aminoxide HBr. makes any possibility of the development of psychiatric disorders in 'normal' people extremely unlikely."[1]

From the well known properties of scopolamine the possibility of intoxication with the development of a transient psychotic reaction could be expected.

A search of the literature has not disclosed any reported toxic psychoses, such as the one detailed below.

CASE REPORT

Our patient was an 18 year old white single female, without any history of mental disorder in the family. She grew up as an only child. Soon after her birth the parents were divorced. As the family structure composed of the patient, her mother, stepfather and foster sibling was a loose one, the insecurity therein prevented the development of a mature and adequate personality structure. The patient had some difficulty in interpersonal relations but developed no neurotic or psychotic patterns of maladjustment. She enjoyed good physical health throughout her life.

After breaking off an engagement, the patient started to date a married Negro man. Soon this situation became too difficult for her to manage. Due to social pressures, she felt that she had to hide this relationship and so she became overly cautious and conscious of her own behavior and the reaction of other people to this. However, she did not develop any signs of a psychosis either subjectively or objectively.

In a possible suicidal gesture she took 35 tablets of sominex.® Within two to three hours somnolence and thick speech developed. Her conversation changed from normal to an irrational and disorganized discourse with a predominantly paranoid ideation, the delusions centering around previously subconscious feelings of guilt concerning her affair. Intermingled with this were short periods of a few sentences with normal thought processes. This behavior lasted for about 12 hours and became so disturbing to the family that the local physician referred her to the State Institute of Psychiatry for admission.

Examination upon admission showed a pulse rate of 134, but the other physical findings, including the blood pressure of 124/82, were within normal limits. The neurological examination revealed no significant pathological changes. The reflexes were active and equal.

Upon admission, 12 hours after ingestion of the drug, the patient was already convalescent from the delirium but still slightly lethargic. She recalled vividly and readily described her previous delusional state.

A urinalysis done at the time of admission showed 120 mg. per 100 cc. albumin, with hyaline and granular casts. These findings gradually disappeared within the next eight days. The serum bromide level was 37 mg. per 100 cc. upon admission, and 0 mgs. per 100 cc. after eight days.

The patient recovered completely under conservative management within a few days except for the previously mentioned personality difficulties.

CONCLUSION

The production of a transient toxic delirium with paranoid psychotic ideation followed ingestion of 35 tablets of sominex® containing 8.75 mgs. of scopolamine aminoxide HBr, 875 mgs. of methapyrilene HCl. and 7 gr. of salicylamide. The patient recovered completely under conservative treatment. Since a prescription is not necessary, sominex® is widely used and similar reactions in other cases may be expected.

REFERENCE

1. Personal communication from Pharmaceuticals, Inc.

Submitted August 6, 1956.

The Authors

● Dr. May, Columbus, is resident psychiatrist at Columbus Receiving Hospital and State Institute of Psychiatry.

● Dr. Voegele, Columbus, is resident psychiatrist at Columbus Receiving Hospital and State Institute of Psychiatry.

Comparison of Incidence of Reactions to Penicillin

Four mild cutaneous reactions occurred in a group of 385 patients receiving intramuscular injections of procaine penicillin G in aqueous suspension at the Mayo Clinic in 1952 and 1953. This incidence of 1 per cent compares favorably with an incidence of 0.75 per cent reported in 1948 after administration of the same agent suspended in sesame oil.—Donald J. Corr, M. D., and William E. Wellman, M. D., Rochester, Minn.: *Minnesota Med.*, 39:678, October, 1956.

Emergency Care of Head Injuries*

MAX T. SCHNITKER, M.D.

IT IS the recognition of the extent of the injuries sustained and the proper institution of basic surgical principles that constitutes the emergency care of head injuries.

The initial step in the treatment of an acute head injury is to obtain an adequate history in order to determine the mechanics of how the injury occurred as well as to determine the site of the maximum injury to the scalp and skull. These facts are important since it is generally held that a stationary head injury in which the fixed head is struck by a moving object is generally less severe, considering the brain as a whole, than is the accelleration-decelleration type in which the head is moving and is brought to an abrupt stop by a fixed object. In other words, it is the rate of change in velocity rather than the momentum that increases the severity of the injury.

DEGREE OF UNCONSCIOUSNESS

A second principle is the determination of the initial degree of unconsciousness at the time of injury and then noting any change in the conscious state that follows. A convenient yardstick is a classification into one of four degrees of unconsciousness that is of practical value in following the patient.

Grade I is akin to *sleep* from which the patient can be roused easily and is oriented in all spheres. Obviously the brain injury is minimal and requires only observation and no special treatment.

Grade II is called *stupor* in which the patient can be roused by a fairly strong stimulus to give a few pertinent facts of life-long interest as his name, age, residence, etc., but cannot give an account of recent events. He very quickly lapses back into his stuporous state and is roused again with increasing difficulty.

Grade III is called *semi-coma* in which he responds to painful stimuli only by movement and cannot cerebrate rationally. Occasionally a phase of *restlessness* occurs somewhere between stupor and semi-coma that may reach near violence. The patient cannot be reasoned with in this state even though he may be responding some.

Grade IV is frank *coma* in which state the patient does not respond to any painful stimuli, the pupils are dilated and the breathing stertorous. The condition is grave. Echlin[1] in New York reported recently that of 50 such cases in deep coma, 20 per cent (10 cases) had convulsions. All 50 were operated upon within 48 hours with a mortality rate of 90 per cent, even though a hematoma may have been evacuated.

A general physical examination to determine the status of the circulation, internal injuries, fractures and a neurological examination completes the general appraisal of the situation.

TREATMENT

The main sources of energy used by the brain in its metabolism are oxygen and carbohydrates. Therefore it is of primary importance to maintain an adequate airway in the unconscious patient. It may be necessary at times to perform a tracheotomy to insure adequate respiratory exchange. This should be done early rather than late if the patient is to benefit from it. If pure oxygen is administered by catheter or mask, it should not exceed four liters per minute since higher concentrations in the presence of brain edema are known to maintain coma rather than to relieve it.

The treatment of shock takes precedence over all other measures once an adequate airway is provided. However, shock is seldom a serious problem in head injuries alone. When shock is progressing or severe, one should look for internal injuries, fractures of the extremities or frank hemorrhage to account for it. Whole blood is still the best agent to combat this shock, be it primary or secondary, especially in children.

Since carbohydrate is necessary in normal brain metabolism, an infusion of 5 per cent glucose in distilled water can be administered while the blood is being obtained. Normal physiologic saline should be used subsequently rather than water since the lack or loss of serum sodium to below 120 mEq. promotes water intoxication with convulsions and coma. If acute alcoholism is evident along with the head injury, it is advisable to administer 10 per cent glucose in distilled water as a mild hypertonic solution as well as to supply glucose for the liver.

As a further adjuvant for the treatment of severe shock, concentrated serum albumin, 60 to 90 cc., or 100 cc. of 50 per cent glucose or sucrose can be used intravenously. It is felt these agents

*Read before the Symposium on Trauma, Organizational Meeting, Ohio Chapter, American College of Surgeons, Columbus, Ohio, September 28, 1956.

The Author

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act to restore circulating blood volume rather than to combat cerebral edema directly.

ROENTGENOGRAMS

The patient should be kept flat and quiet during this emergency care. He should not be moved for the purpose of making roentgenograms of the skull. In the first place, he usually is not cooperative so that the x-ray photographs are usually unsatisfactory and have to be repeated later, particularly for legal purposes. Secondly, no one ever died of a fracture of the skull per se, so that the presence of a linear fracture is of no immediate significance in the management of the head injury. If a linear fracture implicates a paranasal air sinus or the ear, the administration of antibiotics is advisable.

There are three indications for early roentgenograms of the skull to be made as soon as the shock state is under control. These same three indications hold for early operation also as soon as the patient's condition permits, namely:

1. Compound or depressed fractures of the skull.
2. Gunshot wounds of the brain.
3. Fractures across the middle meningeal artery channel when an extradural hematoma is suspected.

In these instances, the patient should be kept in bed and a portable x-ray unit used without any manipulation of the patient's head. All other x-ray photographs of the skull are made just before the patient leaves the hospital.

Lumbar puncture has no place in the emergency care of the acute head injury. It is desirable to have it done later for diagnosis of the extent of subarachnoid bleeding only after the patient's condition is well stabilized or in 24 hours if he has reached a plateau and is not improving properly. Obviously the Quackenstedt test should never be done in any case.

SEDATION

The selection of sedatives and analgesics may be a very difficult one. Small doses of codeine or demerol® should be given only for pain and not for sedation. The best sedatives for restlessness are sodium luminal® gr. 2 intramuscularly for severe restlessness or convulsions. Chloral hydrate and potassium bromide gr. 20, each is an excellent combination by mouth and has no altering effect on the vital signs. Morphine is never administered because of its masking effect on the pupillary reactions as well as its known augmenting effect on cerebral edema already present. Emptying a full bladder is sometimes a miraculous cure for restlessness in the stuporous patient.

All fractures should be splinted without manipulation and all obvious bleeding controlled as soon as possible by careful surgical technic. In lacerations of the scalp, the surrounding area should be shaved and cleansed and then with a sterile glove, finger palpation should be carried out over the underlying skull. In case of a small puncture wound, it should be enlarged with a scalpel sufficiently to admit a finger. Instruments should never be used in probing beneath the scalp. If it is decided to close the scalp by primary closure, the wound should be debrided carefully and the wound closed in two layers, first the galea and then the skin. In using a full thickness suture, a depressed scar will result if the galea retracts.

This concludes, in a short discussion, the emergency care of head injuries. When the patient has recovered from the initial shock state, he is then transferred to his bed and the "cranial check" begun of recording his blood pressure, pulse and respirations at regular intervals of 15 to 60 minutes, depending on the circumstances. This aids in the evaluation of changing neurological signs.

Finally, as stated by Dowman[2] of Atlanta, about 20 to 30 per cent of head injuries are taken care of by God, 55 to 60 per cent get well on good nursing care and the final 5 to 10 per cent require surgical operation in their management.

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Polypoid Degeneration Of the Nasal Sinuses

Polypoid degeneration of the nasal sinuses is not an uncommon condition in our everyday practice, but it is commonly poorly or neglectfully managed. Undoubtedly because of the slow development in chronicity of the condition, the patient can hardly remember when he did not have disagreeable nasal symptoms, and he has been encouraged to accept the disability. That this condition is potentially dangerous is readily seen when one realizes that in almost all of these cases there is a residual chronic infection in the depths of the polypoid and hyperplastic masses in the antrum, ethmoids, and sphenoid.

The latest concept, supported by the work of such investigators as Hansel, Schenck, and Kern, is that this multiple polyposis occurs in a perennial allergic rhinitis. The appearance of the mucous or edematous polyp is characteristically a smooth, rounded, pale or grayish pink mass which occurs singly or in large numbers. The polyps are usually multiple and bilateral, and when in large numbers they may fill the nasal cavity producing characteristic nasal obstruction and possibly headache from pressure and improper drainage.—Claude D. Winborn, M. D., Dallas: *Texas State J. Med.*, 52:851, Dec., 1956.

Mistakes in the Use of Chlorpromazine

W. DONALD ROSS, M. D.

THE opportunity to see several patients who had responded unfavorably to chlorpromazine has suggested certain cautions in its use which have not been widely emphasized in the extensive literature on this drug.

CASE REPORTS

Case 1. Mrs. A. was a 52 year old school teacher seen in consultation about her request for a retirement pension on grounds of psychiatric disability. The history relevant to this note was that, when she began to develop a fear that the school children would get hurt, her doctor prescribed chlorpromazine shortly before the summer vacation and continued this through the summer. She became depressed and apathetic with increasing weight loss, suicidal ideas which frightened her, and complete inability to start teaching again in the fall.

After several months in this state she changed doctors and the chlorpromazine was discontinued. She began to feel more cheerful and to regain her weight but she was convinced that she could no longer teach school after this prolonged "nervous breakdown."

Case 2. Mr. B. was a 27 year old salesman seen in consultation for the industrial medical department of his firm because of repeated absences from work on the grounds of fatigue and nervousness. He was being treated by a general practitioner who was prescribing chlorpromazine so that, in the patient's words, "he would not have to see a psychiatrist." The patient had felt a need at first for some opportunity to discuss his problems but with treatment, including two short periods in hospital for physical investigation in addition to the chlorpromazine, he had become increasingly self-reproachful and despairing of his ability to use any help. He showed considerable retardation in speech with repetitive self-depreciation.

The private physician was advised to refer him to a psychiatrist. The psychiatrist selected by the general practitioner arranged for electroconvulsive therapy, beginning in hospital and continuing on an outpatient basis for a total of four treatments. He became hypomanic and this was successfully controlled by chlorpromazine until he became stabilized and was able to resume his work happily and effectively.

Case 3. Mr. C. was a 50 year old scientist under the care of a psychiatrist. The patient's urge to talk about his personal problems during a casual contact was discouraged so as not to interfere with his treatment. It was learned later that he had had a depressive episode in the past which had responded very well to electroconvulsive therapy and that this was being considered again but he was being allowed to continue working at his own insistence and being given chlorpromazine for his restlessness and sleeplessness. While on this medicament and when he was approaching the end of a project without settled plans for the future he suddenly took his own life.

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Submitted August 3, 1956.

The Author

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Observations on five other cases seen in the course of the last two years could be described in further illustration of depressive features being apparently accentuated during the administration of chlorpromazine. A recheck was made of the data on six patients with depressions who had been tried on chlorpromazine during an investigation on the psychiatric wards of the Cincinnati General Hospital.* Three of these patients had been observed to be unchanged on the drug, two had become worse, and one, after one week on chlorpromazine, had shown improvement which continued when the drug was stopped on the next day.

One more case will illustrate the fact that this drug can be harmful or helpful to the same individual depending on the clinical state and psychodynamic balance.

Case 4. Mrs. D. had had intensive psychotherapy but her psychiatrist had left town and she saw her family doctor for symptoms related to the loss of her therapist. She was given chlorpromazine and became depressed and apathetic. She improved somewhat when the chlorpromazine was stopped and resumed psychotherapy with another psychiatrist. With further improvement she contemplated a trip out of town which would be doing to her new therapist what her previous therapist had done to her, i. e., leaving, and she had become fearful that an old phobia for traveling would return.

At this time the psychiatrist considered that the psychodynamic balance was now such as had been observed in patients who were helped by chlorpromazine. (Her aggressions were being directed outward rather than against herself.) Her family doctor was advised to prescribe this drug again, with resultant reduction of her anxiety and of the fears in the course of her trip.

Two letters to the Editor, *American Journal of Psychiatry,* have emphasized that the "ataractic drugs" are being used unwisely in the treatment of depression with needless delay, hardship and complications.[1,2] An editorial in *The Journal of the American Medical Association* sounded a note of caution about the use of these drugs with-

*Appreciation is due to Dr. Stanley L. Block and to the psychiatric house staff of the Cincinnati General Hospital for the collection of these data.

out an understanding of the emotional difficulty and the patient-doctor relationship.[3]

The voluminous literature on chlorpromazine has indicated that it has little value in depressions unless there is considerable agitation and that there are risks of jaundice, and, rarely, of suppression of blood cell formation in the bone marrow. However, there has not yet been sufficient emphasis on the fact that emotional depression can be a *contraindication* for chlorpromazine because it is liable to make the patient more depressed, and result in a delay of more effective treatment, which might be psychotherapy or electroconvulsive therapy, depending on the severity of the depression.

This drug, which has been a milestone in psychiatric treatment, should not be used as a millstone around the patient's neck. *Primum non nocere.*

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Renal Hypertensive Mechanism

We believe that the renal hypertensive mechanism arises from a reduced glomerular filtration rate rather than from ischemia. This thesis is based on the premise that the circulatory mechanisms peculiar to the kidney are oriented primarily for the homeostasis of the glomerular filtration rate. Some of the supporting arguments for this thesis may be presented here. The renal circuit is more generously endowed with blood flow than is necessary for adequate respiration. This excess blood, we believe, is for the purpose of maintaining glomerular filtration; but when this reserve fails, the humoral hypertensive mechanism is brought into play.

Other physiologic evidence is afforded by the renal vascular response to polycythemia. Here the glomerular filtration is maintained in part by afferent dilatation sufficient to allow an increase in blood flow in spite of increased viscosity. A normal filtrate is extracted from a reduced plasma flow (replaced by cells) by elevation in the filtered fraction.

Clinically, hypertension is more closely associated with the clinical affections of the kidney in which the renal disease primarily affects glomerular filtration. These are glomerulonephritis, lipoid nephrosis, intercapillary glomerulosclerosis, and toxemia of pregnancy. Clearance determinations in all these conditions associated with hypertension demonstrate greater decrease in glomerular filtration than in blood flow, and indeed often no reduction in blood flow.—Merrill P. Spencer, M. D., Winston-Salem: *North Carolina M. J.*, 17:561, December, 1956.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met at the Columbus Health Center on November 21, 1956, at 12 noon. Three cases were presented.

Case 36: A 55 year old female, gravida V, Para V, had a surgical menopause following a subtotal hysterectomy. Bloody vaginal discharge was noticed 16 years later. First medical consultation, two months later. Admitted to the hospital. Pelvic examination revealed the cervix to be replaced by an ulcerating tumor mass. Induration in both vaginal fornices. This represented a Clinical Stage II squamous cell carcinoma of the cervix. She received cobalt in the form of colpostat and tandem delivering 2500 R. Patient advised to return in two weeks for continued therapy. No follow-up until five months post-cobalt. Admitted and examination revealed regression of the lesion with no evidence of extension. She received an additional 2600 R. by x-ray.

Comments: DR. JOHN H. HOLZAEPFEL: There was lack of organization in the department. We were responsible for five months delay.

DR. HARRY E. EZELL: Two months patient delay.

Case 37: A 31 year old female, Para III, saw her physician regularly for periodic check-ups. On last visit the cervix was eroded in its entire circumference. A biopsy was done in the office and a diagnosis of squamous cell carcinoma, Clinical Stage I, was made. She was admitted for therapy.

Comments: DR. JOHN H. HOLZAEPFEL: This is a good contrasting case in that the patient saw her physician regularly for check-ups. No delay.

DR. HOLZAEPFEL: The patient should be treated with irradiation followed by radical surgery.

Case 38: A 53 year old female, Para XII, noticed onset of vaginal spotting. One month later she had her first episode of hematuria. No medical consultation for two months when she saw her physician because she was unable to void. She was catheterized. Seen at the hospital two days later with the same complaint. Examination revealed the cervix to be completely replaced by tumor obliterating the upper one-third of the vagina. Both adnexae were thickened. The tumor was felt to extend to both lateral pelvic walls. Cystoscopy revealed invasion of the bladder. Sigmoidoscopy disclosed extension into the rectovaginal septum with involvement of the rectal mucosa. Diagnosis of squamous cell carcinoma of the cervix, Stage IV, was made. It was felt that therapy should be limited to control symptoms.

Comments: DR. JONATHAN BUSBY: Three months patient delay.

DR. ZEPH J. R. HOLLENBECK: If this patient had presented herself for periodic examination, undoubtedly this lesion would have been picked up much sooner.

DR. HOLZAEPFEL: Therapy in a case such as this should be limited to symptomatic care.



A CONTINUOUS state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and assisted by official representatives of the various County Medical Societies of the state.

Since work of the committee is educational as well as statistical, summaries of some of the cases studied by the committee, based on anonymous data submitted, will be published in *The Ohio State Medical Journal* from time to time. Each presentation will be brief but informative. It will contain opinions of the committee, based on the data submitted for review. Two cases of maternal death due to intra-abdominal hemorrhage are presented in this sixth report.

CASE NO. 94

This patient was a 37 year old, white, Para VI, abortus I, who died six hours postpartum. Her past history was not remarkable, and she had not been subjected to surgery. Previous pregnancies consisted of a 12 week spontaneous abortion, followed by five term pregnancies, each delivered by forceps, without complication. This last pregnancy was uncomplicated, and her prenatal care was considered adequate.

In the thirty-seventh week of gestation the patient went into labor spontaneously, and was admitted to the hospital. Normal progress was noted, and when the cervix was 4 cm. dilated, pains every 2 minutes lasting 50 seconds, 0.1 cc. pituitrin® was administered intramuscularly and the membranes were ruptured artificially. An hour and 15 minutes later the patient was fully dilated; she was given 0.1 cc. pituitrin® intramuscularly and then she was taken to the delivery room. At 11.20 p. m. on the same day, she was delivered by low forceps over a midline episiotomy, of a living 5 pound 13 ounce baby, without complication; the placenta delivered spontaneously. Pulse was noted as satisfactory, but blood pressure was not noted.

Slight vaginal bleeding continued after patient was placed in her bed, the uterus relaxed, and at 12:10 a. m. on the following day, the patient passed approximately 300 cc. of blood. She became pale, went into shock, blood pressure 70/40 and it never improved, in spite of intravenous fluids and stimulants. At 1:45 a. m. blood was transfused, and her physician packed her vagina at 2:00 a. m. (There is no note of an examination of the uterus.) From this point on, blood (5 units) was administered, oxygen, fibrinogen and stimulants were given, but the patient expired at 5:20 a. m.

Autopsy: Permission for autopsy was obtained. Examination revealed free blood in the peritoneal cavity (all fresh without clot formation); there was a large laceration along the left side of the uterus which would admit the clenched fist, and extended from 4 cm. below the left ovarian ligament down through the cervix into the vagina, through the myometrium into the uterine cavity, outwardly into the left broad ligament.

Cause of death: Acute intra-abdominal hemorrhage, following rupture of the uterus in labor.

COMMENT

The case was voted preventable (P_2) on the basis of a combination of errors. Members of the Committee felt that on a basis of information afforded in the case, the administration of an oxytocic drug and artificially rupturing the membranes during the first stage of labor, in a multiparous patient in premature labor which was progressing normally, consituted "meddlesome obstetrics." To repeat the oxytocic in the second stage of labor when progress was satisfactory would constitute a second useless and perhaps deleterious procedure. No mention was made of the use of a general anesthetic, but it would appear that in view of a severe uterine hemorrhage, and shock, the cervix and uterine cavity should have been thoroughly examined and explored, before a packing was placed in the vagina.

CASE NO. 103

This patient was a 41 year old, white gravida IV(?), Para III(?) who died undelivered. Past medical and surgical history, and past obstetrical history are not known in detail. Little could be learned concerning the present pregnancy, for she had not seen any physician. Nor was the Committee furnished information concerning symptoms the patient experienced before her death.

The patient died at home and was viewed by the coroner after death. An autopsy was performed the day after death and revealed the following findings pertinent to the female pelvis:

"There is a marked amount of free blood in the abdominal cavity, and many clots. There is a marked amount of clot about the fetus, which

is inside the amniotic sac; the fetus is a male, measures 11 cm., and placenta is attached to the cord. The uterus is 12 by 7 by 5 cm; on section through the region of the tear, a large cavity is seen within the upper pole of the uterus. The cavity measures 5 by 6 cm. and lining the wall are fragments of placenta tissue.

"This cavity wall extends to and involves the junction of the right tube and the uterus, thence extending downward into the wall of the uterus. It is conceded to be pregnancy that developed at the junction of the tube and uterus and ruptured into the peritoneum through this tear that was previously described. The endometrium is quite polypoid and profuse. The cervix shows considerable cystic gland formation. *Pathological diagnosis:* Exsanguinating abdominal hemorrhage; ruptured ectopic pregnancy (approximately 14 weeks gestation)."

COMMENT

Once again the Committee felt itself hampered by a lack of adequate information in the case, particularly details concerning symptoms and signs in the patient during her last pregnancy, and those preceding her death at home. The autopsy findings provide evidence for a diagnosis which caused death, but it is purely a realm of medical imagination which would allow a patient with such bizarre pathological findings, to die at home without some attempt to obtain medical attendance. Based upon data available, the Committee voted the death preventable (P_1), fault of the patient.

COMMENT OF CONSULTANT

The following comment of a consultant, who is a specialist in his field of Obstetrics and Gynecology, was furnished at the request of the Committee.

Case 94. Why physicians persist in using obstetrical pituitrin®, and for that matter why the manufacturer continues to market it when a better product (pitocin®) is available, is beyond my understanding. Even so, the use of pitocin® or any other oxytocic drug during the first stage of labor is dangerous as is well exemplified here. Furthermore, if pitocin® or a like preparation is indicated in labor, it should always be given in much smaller amounts than minims. It should be diluted at least 1 to 500 and given by intravenous drip so that the amount and its immediate effect can be well controlled.

An apparently normal infant was delivered in this case in spite of the conversion of a normal labor by the use of pituitrin® and artificial rupture of the membranes to a precipitous labor, and especially when the infant was somewhat premature.

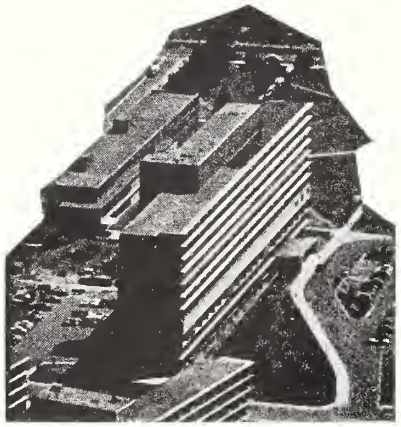
Somewhat delayed postpartum shock out of proportion to the amount of visible blood loss is almost pathognominic of rupture of the uterus. In a case of an extensive uterine rupture a frequent error is the impression that one is dealing with uterine atony especially when the rupture occurs laterally, and a large hematoma is found in the broad ligament. This large collection of blood is mistaken, on abdominal examination, for a soft, atonic uterus which when massaged seems to contract down with the expression of much blood, fluid and clotted, from the vagina.

The management of postpartum shock is first to combat the shock by immediate and adequate blood transfusion using Rh negative, type 0 blood without crossmatching, if necessary. While this is being done the patient should be receiving oxygen, a clot observation test should be carried out to detect the presence of hypofibrinogenemia, and the operating room should be made ready. When shock is under control (systolic blood pressure 80 or above and pulse 110 or below) and only then, and furthermore without delay, the patient should be adequately examined and the appropriate corrective surgery done. Adequate examination consists of adequate anesthesia, adequate light and exposure, and adequate assistance.

The diagnosis of the cause of bleeding in ruptured uterus, uterine atony or retained placenta (and accreta) can only be positively made with the examining hand in the uterus. With adequate exposure the diagnosis of laceration of the cervix or the vaginal wall or bleeding from the episiotomy can be made easily. Suture ligature will control bleeding from these points, and vaginal packing is usually a waste of time (and gauze). Vaginal packing does accomplish one thing, however; it further conceals the concealed hemorrhage.

Case 193. This condition of ruptured interstitial or cornual pregnancy produces the most dramatic and serious shock seen in ectopic gestation. Here again the crux of successful management is the control of the shock and blood replacement before anesthesia or operative interference is begun.

It has been said that the immediate control of the point of hemorrhage is the most important consideration in ruptured ectopic because "the blood will run out as fast as it can be put in." This is not true because when the patient is in shock the bleeding stops. When the blood is replaced or partially so and the blood pressure returns to a substantial level, bleeding will begin again, of course. Obviously it is extremely important to proceed at once with surgery when the shock has been controlled (systolic pressure 80 or above and pulse 110 or below). It has also been noted that there is a dramatic response to the control of the point of bleeding. The drama becomes a tragedy if the patient subsequently expires. This outcome can be averted if the shock is controlled before anesthesia or surgery is begun. It should be remembered that the apparent dramatic response to the control of the bleeding point in intra-abdominal hemorrhage is due primarily to the blood replacement.



A Case Record

From The University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Ralph J. Johansmann, M. D., President

Presented by Roger D. Williams, M. D., and Emmerich von Haam, M. D. Edited by Dr. von Haam

PRESENTATION OF CASE

A FIFTY-EIGHT YEAR OLD WHITE male was admitted to the hospital with the chief complaint of cramping lower abdominal pain of 36 hours' duration. There had been no previous pain, no change in bowel habits, no constipation or melena. He had no distention, no nausea, vomiting or hematemesis. There was no jaundice or back pain. He did have a small bowel movement the day prior to admission.

The past history showed an appendectomy at the age of 11 and pneumonia four years ago. The patient had been taking digitalis, 1 tablet every day, for the past two years. He was said to have been in heart failure two years ago with mild dyspnea and edema. However, two electrocardiograms at that time were reported normal and the roentgenogram taken at that time showed no cardiac enlargement. There had been no dyspnea, orthopnea, chest pain, or edema since then. He had noted no dysuria or nocturia.

PHYSICAL EXAMINATION

On admission the patient showed a temperature of 103°F., pulse 116, respirations 20, blood pressure 150/95. He was definitely in severe lower abdominal distress. The pupils were round, regular and equal and reacted to light; the fundi were normal. The neck was supple. The right lobe of the thyroid was prominent. The chest showed increased anteroposterior diameter; the resonance was increased; the chest was clear and there were no rales. The heart sounds were distant; the left border of cardiac dullness could not be delineated. There was some tachycardia, which was regular.

The abdomen was not distended. The right lower quadrant showed an appendectomy scar. There was guarding in the left lower quadrant with rebound tenderness, rare high-pitched bowel sounds were present; no masses were felt, no hernia was detected. The rectal examination showed marked tenderness but no masses. The extremities showed no edema.

LABORATORY DATA

On admission the red blood count was 5.2 million, hemoglobin 15.2 Gm., white blood count 16,900 with 82 per cent segmented forms, 13 per cent nonsegmented, 4 per cent lymphocytes and 1 per cent monocytes. Examination of 22 cc. of cloudy yellow urine showed a specific gravity of 1.031, *p*H 6, protein 10 mg., sugar 2 plus; 4 to 6 hyaline casts, 2 to 4 granular casts and 33 to 34 white blood cells per high powered field, a few calcium oxylate crystals and much mucus. The prothrombin time was 74 per cent; CO_2 combining power 60 vol.; amylase 42 units; chlorides 105 mEq., potassium 5.1 mEq., sodium 150 mEq. The blood urea nitrogen was 18 mg.

X-RAY EXAMINATION

His abdominal films showed slightly dilated loops of small bowel. At least three or four loops of small bowel had good fluid levels indicating stasis. There was gas scattered through the right and transverse colon and a little bit in the descending colon. He also had some fluid levels in the right colon. From these findings a diagnosis of early mechanical or intermittent obstruction was made.

HOSPITAL COURSE

On the day of admission resection of the sigmoid colon with a proximal colostomy was performed. The patient did well until the fourth day, when his abdomen suddenly became distended; this was relieved with Levin tube and suction, and the patient seemed improved until the sixth day. On this day his temperature spiked to 105°F. The abdomen was soft, without pain; the bowel sounds were quiet. The pulse was rapid, the blood pressure low. Electrocardiogram showed only sinus tachycardia. There were rales in the left base. The white blood

count on this day was 15,600; the blood chlorides were 101 mEq, the blood urea nitrogen 121 milligrams.

On the seventh day the sodium was 141 mEq., potassium 5.2 mEq., and chlorides 94 mEq.; CO_2 was 64 vol. The white blood count was 42,000 with 58 per cent segmented neutrophils and 14 per cent nonsegmented, normal hemoglobin and red blood count.

On the eighth day there were noted definite physical signs in the abdomen consisting of marked abdominal distention and tenderness. The urinary output began to fall. A diagnostic paracentesis was done to the abdomen and the material obtained showed many pus cells and gram-positive and gram-negative rods. The CO_2 was 35 vol., the blood urea nitrogen 154 mg., sodium 140 mEq., potassium 7 mEq., chloride 111 mEq. Chest x-ray on this day showed no evidence of any pneumonic infiltration. Grossly bloody material was noted in the gastric suction.

The patient received vasopressor drugs, massive antibiotic therapy and intravenous fluids. He was also given intravenous cortef.® In spite of these measures the patient died in shock on the ninth day.

CLINICAL DISCUSSION

DR. R. D. WILLIAMS: In summarizing the history of this case, we have a 58 year old man who came to the hospital 36 hours after the onset of lower abdominal pain which was associated with marked abdominal tenderness and rebound tenderness in the lower abdomen and a rather marked elevation of temperature and pulse. Furthermore there was x-ray evidence of intestinal obstruction. These symptoms mean that his intestinal obstruction was due to some inflammatory process, and in a 58 year old man an intestinal obstruction due to inflammation, particularly since we know the appendix was out, should mean, just as a guess of frequency, diverticulitis.

Based on the physical findings, his abdominal condition was considered a mechanical obstruction. There were high-pitched bowel sounds and it was the impression of the surgeon that this represented mechanical small bowel obstruction on the basis of an inflammatory process. He was operated upon and according to our prediction they found a diverticulitis with rupture. The sigmoid colon was resected and a proximal colostomy was performed.

The patient apparently did extremely well for the first three or four days after operation. His abdomen was soft and interestingly enough remained soft until the day before death. I think this is quite important, because on the fourth day he developed marked ileus, distention, and on the sixth day he developed a complication which in my opinion led to his demise. This complication was definite shock, which developed rather rapidly within a period of a few hours and was associated with hyperthermia. It apparently looked as though the shock was due to some severe toxic reaction producing fever, and of course the first thing one thinks of is the possibility of peritonitis.

When shock develops in the postoperative period in a patient with a known previous cardiac disease, there are a number of diagnoses to be considered. The first is massive pulmonary edema. The second one which we might consider as a possibility, since we know that the patient had rather severe pneumonia once before, is that he might again have pneumonia as the result of an atelectasis which had not previously been picked up. Pneumonia rarely occurs spontaneously following surgery.

Finally, his shock might have been on the basis of coronary occlusion. Other conditions which will produce shock and a high elevation of temperature are peritonitis, pancreatitis, pulmonary embolus, and finally gangrene of the intestinal tract as the result of an embolus from his heart or thrombosis of one of the mesenteric vessels. Let us discuss all of these possibilities.

POSSIBILITIES

An x-ray photograph taken the day after he went into shock showed no evidence of pulmonary edema, pneumonia or embolus. Furthermore, electrocardiograms taken on several occasions during the postoperative period pretty much ruled out the possibility of a coronary occlusion. This patient went into shock and remained in shock for three days until the time of his death. We know that if a pulmonary embolus had been the cause of this he would have developed an infarct with pneumonia or abscess in this period. Otherwise patients get over the period of shock within a few hours or they don't survive it. I think we can rule out a coronary occlusion on the basis of the electrocardiogram, since a coronary occlusion producing this degree of shock for such a long period of time certainly would have been recognized by the electrocardiogram.

We then are forced to explain the shock on the basis of something which happened in the abdomen, and I think that his protocol supports that theory. Let us consider the possibility of pancreatitis. I don't believe this patient had pancreatitis since it is a rather uncommon complication following lower abdominal surgery and when it does occur postoperatively it occurs within the first 72 hours. His episode of shock did not occur until the sixth postoperative day, he never complained of back pain, and his abdomen remained soft for at least two days after the onset of shock. In pancreatitis you also would not expect such a high temperature early in its course, not until secondary infection has set in.

Also, I do not think that the patient developed gangrene of the intestinal tract since this condition always causes tenderness at the site of

gangrenous bowel and one usually can palpate a tender mass. We know that just prior to his death a peritoneal aspiration produced purulent fluid containing gram-positive cocci and gram-negative bacilli. This undoubtedly means that we have to think of peritonitis unless the person doing the peritoneal tap sucked purulent material out of the intestinal tract.

There have been recent articles suggesting that pseudomembranous enterocolitis is becoming a relatively common postoperative complication. Most cases that have been reported have not been diagnosed antemortem, and the reason for this is that they imitate all the diagnoses that I have discussed here. They can suggest a massive pulmonary embolus, pancreatitis, and certainly peritonitis or gangrene of the intestinal tract. It is thought that the increased incidence of this surgical complication is due to the widespread use of antibiotics. The clinical findings are usually those of a rather severe catastrophe occurring with rather severe temperature elevation and marked shock developing within a few days following gastrointestinal surgery, and many of these patients have been on antibiotics.

ANTIBIOTICS

This particular patient was on streptomycin and penicillin given postoperatively probably for the inflammatory process found in the peritoneal cavity originally. When the patient went into shock he was also started on tetracycline and terramycin,® and if I am correct in my diagnosis all those antibiotics are contraindicated since they all further an overgrowth of gram-positive organisms in the gastrointestinal tract.

Three different forms of pseudomembranous enterocolitis have been described: the choleric form, the form in which paralytic ileus is the pertinent finding, and one in which shock is predominant. Our patient had his acute abdominal episode on the fourth day and went into shock on the sixth day. He never did develop diarrhea. Throughout the period of shock he became an electrolyte problem and lost large amounts of gastric contents through the Levin tube. So this might suggest the possibility of the paralytic ileus as well as the shock type of postoperative pseudomembranous enterocolitis and increases greatly the problem of correcting the shock, which is due not only to the loss of protein-rich fluids through the intestinal tube but through the wall of the bowel as well, with repeated hemorrhages into the gastrointestinal tract.

The postoperative treatment of this patient centered on the treatment of shock, which became the primary problem. We know of a few patients who recently have gotten over this severe complication by adequate treatment of shock, changing of the antibiotics and the use of erythromcyin in order to combat the predominant gram-positive organisms of their intestinal tracts. Adrenocortical hormones and ACTH were given as a last resort in this case and certainly could not have been of much help since the patient was moribund by then.

THE ELECTROLYTES

I have not discussed in detail the fluid and electrolyte problems of this case, which led to an increase of the blood urea nitrogen postoperatively and furthermore caused a shifting between the blood potassium and chloride levels. However, I believe that in a patient with that severe degree of shock it is extremely difficult to control the fluid and electrolyte balance. He had to receive tremendous quantities of fluids, both blood and saline, in order to combat the shock, and I think that the patient could have controlled his own electrolyte balance better if he had not lost his renal function. I consider that his elevated blood urea nitrogen was due to prerenal as well as renal factors. The prerenal factors were the inflammatory process within the bowels and the peritoneal cavity with destruction of tissue and hemorrhage into the gastrointestinal tract. The renal factors were caused by the poor renal circulation as a result of his shock.

In conclusion then I would like to state that I think this patient died from pseudomembranous enterocolitis, a relatively uncommon postoperative complication which is, however, becoming more common and which should always be thought of in a patient who develops severe shock, paralytic ileus or diarrhea without abdominal tenderness some days after being operated upon, particularly when this patient has received large doses of certain antibiotics. I believe that previously he had suffered from a diverticulitis for which a bowel resection was carried out and a diverting colostomy performed. I do not consider peritonitis due to a leakage of the suture line or due to rupture of another diverticulum as a likely possibility. Frankly, I have not seen a leakage of a suture line when a proximal diverting colostomy has been performed.

GENERAL CLINICAL DISCUSSION

MEDICAL STUDENT: I wonder if you could tell us approximately how long it would take for this pseudomembranous enterocolitis to develop after antibiotic therapy?

DR. WILLIAMS: I have not looked up our own cases here as to what the time interval is. I believe that this complication is prone to occur on any type of antibiotic, and since penicillin and streptomycin are the most commonly used antibiotics the incidence reported with these antibiotics is highest. You will recall that many broad spectrum antibiotics, such as terramycin® and aureomycin,® tetracycline and chlortetracycline, have been known to produce relatively severe diarrhea and this staphylococcal diarrhea is very similar to pseudomembranous enterocolitis.

DR. RYAN: Do you think the patient had heart

disease with the normal electrocardiogram, normal sized heart and lack of symptoms?

DR. WILLIAMS: Well I did not discuss his heart disease. From the record I have here I could not tell whether he had heart disease at all except that he had been under treatment for heart disease and was on digitalis.

MEDICAL STUDENT: Do you think he had kidney disease before?

DR. WILLIAMS: I did not consider that he had kidney disease; with a normal blood urea nitrogen and good urine concentration I have no way of knowing that he had kidney disease. I doubt that he did.

There is one thing I do not understand. The aspirate from the peritoneal cavity was reported as loaded with bacteria of all types. If this patient had enterocolitis I would like to know how he developed a bacterial peritonitis? Maybe they tapped the distended bowel instead of the peritoneal cavity.

MEDICAL STUDENT: Do you recommend erythromycin routinely on patients with gastrointestinal surgery to avert this complication?

DR. WILLIAMS: This touches the whole problem of postoperative antibiotics. If one is going to do an elective operative procedure, then the antibiotic should be given preoperatively, not postoperatively. If the bowel is adequately prepared and cleaned, antibiotics are not needed in this postoperative period.

Our patient poses another problem. The bowel was not sterilized because there was no time for sterilizing it, and furthermore the bowel had ruptured, so a local or perhaps a general peritonitis had to be treated with the antibiotics. Erythromycin has a wide spectrum and possibly might be a good antibiotic to give prophylactically and in the management of peritonitis. I don't believe, however, that peritonitis was a big problem postoperatively, because the patient was apparently doing quite well for the first four days, noted no distention and no tenderness. His peritonitis must have been limited.

CLINICAL DIAGNOSIS

1. Acute diverticulitis of colon with rupture and peritonitis.
2. Postoperative pseudomembranous enterocolitis.
3. Shock.
4. Prerenal and renal azotemia.

PATHOLOGICAL DIAGNOSIS

1. Acute diverticulitis of colon.
   a. Status 8 days post-resection of sigmoid colon and colostomy.
   b. Localized abscess formation.
2. Pseudomembranous enteritis.
3. Uremia.

PATHOLOGICAL DISCUSSION

DR. EMMERICH VON HAAM: The peritoneal cavity appeared clean and therefore Dr. Williams' suggestion that the paracentesis tapped the ileum or the jejunum was correct. The diaphragm was high and the small intestines were markedly distended, suggestive of a paralytic ileus. Both lungs showed a marked atelectasis without pneumonic infiltration. The heart was normal in size but his coronary arteries were markedly sclerosed. The liver was slightly enlarged. The esophagus appeared slightly eroded from the gastric tube.

The stomach was greatly distended and filled with a foul-smelling liquid. The small intestines were also distended and the mucosa was completely covered with a greenish yellow membrane. When the membrane was pulled off there appeared a bright red, highly inflamed surface beneath it. The lumen of the small intestine was filled with the same foul-smelling liquid. No liquid got beyond the ileocecal valve, which explains why the patient did not have diarrhea and why he lost all the fluid through the gastric tube.

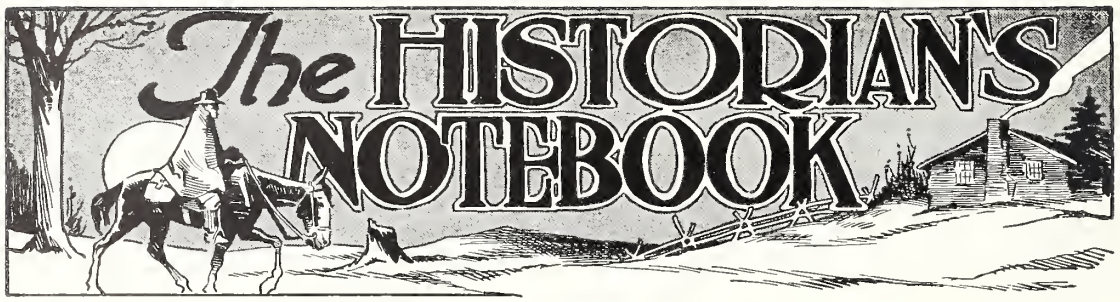
The colostomy appeared in good order, but the colon beyond it was very markedly distended and there was a small leak in the surgical anastomosis which was surrounded by a well sealed off retroperitoneal abscess. This abscess measured 4 cm. in diameter and contained up to 10 cc. of fecal matter. The kidneys were enlarged and weighed 250 grams each but otherwise appeared normal.

MICROSCOPIC EXAMINATION

The heart muscle showed a rather severe parenchymatous and fatty degeneration, indicating severe toxemia, and some old patchy fibrosis. The lungs of course showed marked atelectasis. The liver showed marked fatty changes which suggested recent weight loss, not uncommon in patients with gastrointestinal surgery. The kidneys showed only mild tubular degeneration and marked glycogen infiltration from his intravenous glucose. His azotemia must therefore have been primarily prerenal. The esophagus showed superficial ulceration with acute esophagitis.

The surgical specimen of sigmoid colon showed a severe diverticulitis with the formation of fecal abscesses and localized peritonitis. The small intestine showed extensive necrosis of the entire mucosa with a pseudomembranous inflammatory reaction similar to the lesions produced in the pharynx by the diphtheria organism. The necrosis of the mucosa created a vast denuded surface through which bacteria and toxins could be absorbed into the circulation. Bacterial culture of the intestinal surface revealed Pseudomonas, Enterococci and E. coli. Pseudomonas could also be grown from the blood taken from the heart.

Our autopsy thus fully confirmed the clinical diagnosis made by Dr. Williams and illustrates one of the more recent and most threatening complications of abdominal surgery brought about by the use of antibiotics.



The Medical Men in George Washington's Life

VICTOR R. TURNER, M.D.

PART II *(Concluded from January Issue)*

IT WAS a bright autumnal morning in the latter part of September, 1780, that General Washington accompanied by General Lafayette, Dr. Wm. Burnet, Surgeon General of the Eastern Department and a member of Washington's official family, together with other officers pushed rapidly forward on horseback through the gorges of the Highlands on their way to General Benedict Arnold's quarters. As they came opposite to West Point, Washington instead of continuing on turned his horse down a narrow road toward the Hudson River. Lafayette, observing this, exclaimed, "General, you are going in the wrong direction! You know Mrs. Arnold will be waiting breakfast for us and that this road will take us out of the way."

"Oh," replied Washington laughingly, "I know you young men are all in love with Mrs. Arnold and wish to get where she is as soon as possible. I must ride down and examine the redoubts on this side of the river and will be there in a short time." The officers preferred not to proceed without him, so Dr. Burnet and another aide were dispatched to tell Arnold not to wait breakfast.

THE LAST BREAKFAST

It was while dining at the table of Benedict Arnold that a messenger entered and handed a letter to Arnold who opened it and read it in the presence of the company. It was from Colonel Jameson commanding at North Castle announcing the capture of the spy Major André. Arnold preserved perfect composure, proceeding with the breakfast as if the announcement was of no moment. After a time he excused himself, merely remarking that his presence at West Point was necessary and requested the aides to tell Washington he was unexpectedly called across the river and that he would be back soon. Repairing to his wife's chamber, he sent for her at the breakfast table and told her that he must leave her and his country forever. Thus, Dr. Wm. Burnet of Newark, New Jersey, was an eyewitness to the treason of Benedict Arnold.

Submitted August 21, 1956.

The Author

● **Dr. Turner, Newark, Ohio, now retired, was formerly roentgenologist and radiologist at the Newark City Hospital.**

Dr. Burnet was a close friend of Washington and also Lafayette. The doctor graduated from Princeton and studied medicine under Dr. Staats in New York. He was the leading physician of Newark and in 1765, started the New Jersey State Medical Society, the first in America. He was an intense patriot and was a member of the Continental Congress in the winter of 1776-77. Later he became Surgeon General of the Eastern Department.

Many physicians who were close friends of Washington became officers of the line instead of enlisting in the medical corps. Among these were Dr. Arthur St. Clair who advised Washington to attack the British at Princeton, thereby bringing a disastrous defeat to the enemy. General St. Clair later became Commander in Chief of the Army when Washington was President.

GENERAL HUGH MERCER

It was at the battle of Princeton that General Hugh Mercer, a Scotch physician, was killed while fighting the British in a hand-to-hand conflict. General Mercer had been a close friend of General Washington since they fought in the French and Indian War together. Dr. Benjamin Rush and Dr. Jonathan Potts were sent by Washington under a flag of truce to attend Dr. Mercer before he died.

Dr. John Hazelett, of Delaware, was also killed in the battle of Princeton.

Dr. James McHenry who was born in Ireland and came to America in 1771, was at first in the Medical Corps and later transferred to the line. He was Secretary to General Washington in 1778, and later, in 1780, he was *aide de camp* to Gen-

eral Lafayette. After the war he became Secretary of War from January 29, 1796, to May 13, 1800. Fort McHenry, the scene of the incident which inspired Francis Scott Key to write "The Star Spangled Banner," was named in his honor.

Strange as it may seem two other physicians serving under General Washington later became Secretary of War. They were Dr. Henry Dearborn for whom Fort Dearborn, now the city of Chicago, was named and Dr. Wm. Eustis of Boston.

Of the first seven commanders of the United States Army, three—Wilkinson, St. Clair, and Dearborn — were educated as physicians and served under Washington.

Perhaps the most able physician professionally under Washington's command was Dr. Benjamin Rush. He was born in Philadelphia, December 24, 1745. He graduated from Princeton in 1760, and received his medical degree from the University of Edinburgh in 1768. He also studied in London and Paris. He became professor of chemistry in the College of Philadelphia in 1769, and was one of the faculty of the first medical school in America. He continued to teach for 44 years.

In 1776, he was a member of the Continental Congress and he signed the Declaration of Independence along with five other doctors. He was Physician General of the Middle Department and Washington held his medical ability in high esteem. There was a rumor that Dr. Rush was somewhat in favor of displacing General Washington by General Gates at Valley Forge. However, Washington evidently forgave him because after the war he appointed him as Treasurer of the National Mint, a position which he held the last 14 years of his life.

WASHINGTON DEVELOPED A CARBUNCLE

When General Washington was inaugurated President of the United States, his health gave Dr. Samuel Bard in New York plenty of concern. The President developed a carbuncle of the thigh, which Dr. Bard operated upon. Pneumonia set in as a complication, and it took 109 days for him to recover. Dr. Bard was credited with saving his life. The doctor was very prominent in New York, having founded the first hospital there, and took a leading part in establishing the first Medical School in New York City.

A year later, Washington had another attack of pneumonia and Dr. John Jones made an emergency trip from Philadelphia to New York to care for the President. Dr. Charles McKnight was called in as a consulting physician. Dr. Jones was the family physician until the doctor's death in 1791.

Between 2 and 3 o'clock on Saturday morning, December 14, 1799, General Washington awoke Mrs. Washington and told her that he was very unwell, and that he had had a chill. He was hoarse and breathed with difficulty. Mrs. Washington awoke Mr. Tobias Lear, Washington's secretary, and he sent for Dr. James Craik and also Mr. Rawlings, an overseer. Rawlings came in first and at the General's insistence bled him. In the meantime, before Dr. Craik arrived, Mrs. Washington desired that Dr. Gustavius Brown, the son of Washington's old friend, Dr. Wm. Brown and recommended by Dr. Craik, be sent for. Dr. Elisha Dick also was sent for.

THE FINAL CONSULTATION

Upon the arrival of the doctors a consultation was held and the General was again bled. After this he could swallow a little and calomel and tartar emetic were administered without effect. In the course of the afternoon, he appeared to be in great pain and distress from the difficulty in breathing, and frequently changed his posture in bed. About 5 o'clock Dr. Craik came again into the room and upon going to the bedside, the General said to him, "Doctor, I believed from my first attack that I should not survive it. My breath cannot last long." Dr. Craik pressed his hand, but could not utter a word. He retired from the bedside and sat by the fire in grief.

Between 5 and 6 o'clock, Drs. Brown and Dick came into the room and with Dr. Craik went to the bed. Dr. Craik asked the General if he could sit up in bed. He gave him his hand to assist him in rising. The General then said to his physicians, "I feel myself going. I thank you for your attentions, but I pray you take no more trouble about me. Let me go off quietly. I cannot last long."

At 10 o'clock, he said to Tobias Lear, "I am just going. Have me decently buried and do not let my body be put into the vault in less than three days after I am dead." Mr. Lear bowed his assent. The General then said, "Do you understand me?" and Mr. Lear replied, "Yes." "'Tis well," said the General—the last words he uttered on this earth.

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Proceedings of The Council . . .

Budget for 1957 Adopted at Meetings Held on December 15-16; Reports Filed by Various Committees; Much Miscellaneous Business Transacted

SESSIONS of The Council of the Ohio State Medical Association were held in the Columbus office on Saturday, December 15, and Sunday, December 16, 1956. All members of The Council were present except Dr. Charles L. Hudson, Cleveland, who was unable to be present because of illness. Others attending were: Dr. Jonathan Forman, Editor of *The Journal;* Mr. Wayne E. Stichter, Toledo, legal counsel for the Association; and Messrs. Nelson, Saville, Page, Moore and Edgar.

On **motion** duly made, seconded and **carried**, the minutes of meetings of The Council held on September 15-16 and on November 11, 1956, **were approved.**

MEMBERSHIP STATISTICS

Membership statistics were reported by the Executive Secretary as follows: OSMA membership as of December 14, 1956, 8,828; compared to a total membership of 8,633 on December 31, 1955 — an increase of 195 members. Members of the OSMA affiliated with the AMA as of December 14, 1956, 7,795, compared to a total of 7,512 in 1955—an increase of 283.

Matters pertaining to the Constitution and By-Laws of the State Association and to the constitutions and by-laws of County Medical Societies were then considered by The Council.

Mr. Stichter was instructed to prepare an amendment to the By-Laws of the State Association which would clarify provisions pertaining to the qualifications which a man must possess in order to be eligible for admission to a County Medical Society. The amendment would pertain particularly to the question of residence and practice within a given county. The proposal would be presented to the House of Delegates at the 1957 Annual Meeting.

AMENDMENTS CONSIDERED

A revised Constitution and By-Laws adopted by the Belmont County Medical Society was reviewed by The Council. By official action, **The Council voted not to approve** the document at this time because of certain deficiencies in certain articles. The subject was left pending, subject to further action by the Belmont County Medical Society.

A proposed new model constitution and by-laws for county medical societies was discussed in a general way. President Meiling asked members of The Council to present their comments and suggestions to the Columbus office so that a composite list of recommendations could be compiled prior to the next meeting of The Council.

A series of amendments to the Constitution and By-Laws of the Columbus Academy of Medicine, adopted by that organization on December 5, 1956, were considered. By official action, **The Council approved** certain of the amendments but held over the other amendments for future consideration. The Executive Secretary was instructed to send the complete list of amendments to members of The Council for study prior to the next meeting of The Council.

MEDICAL ASSISTANTS

Correspondence from the Medical Assistants Society of Toledo and Lucas County and the Society of Medical Assistants of Summit County was read and discussed. These letters requested the advice and active assistance of the Ohio State Medical Association in the formation of a State Society of Medical Assistants. The correspondence stated that such organizations are now in operation in many other states and that the idea has the approval of the American Medical Association. By official action, **The President was authorized to name a committee** to cooperate with local societies of medical assistants in Ohio on the matter of setting up a state organization of medical assistants.

DOCTOR-LAWYER CODE

Mr. Stichter reported on the status of the project setting up a proposed code of relationship between physicians and lawyers for use by county medical societies and local bar associations. He pointed out that there were some differences of opinion between the draft prepared by the Judicial and Professional Relations Committee and the draft prepared by a special committee of the Ohio State Bar Association. By official action, The Council supported the provisions drafted by Mr. Stichter and the OSMA committee and advised him to so inform the Bar Association officers and committee. The Council expressed the hope that this project could be completed in the near future. It instructed the Executive Secretary to supply to local medical societies copies of the OSMA draft which could be used by them in their negotiations with local bar associations until such time as a uniform state-wide proposal agreed to by the OSMA and the Ohio State Bar Association is available.

BUDGET FOR 1957

The Council then, in executive session, considered the report of the Committee on Auditing and Appropriations and by official action **approved**

such report. In adopting the report of the committee, **The Council approved** the following budget for the calendar year 1957:

The Ohio State Medical Journal	$ 40,000.00
Executive Secretary, Salary	16,500.00
Executive Secretary, Expense	2,000.00
Administrative Assistant, Salary	8,000.00
Administrative Assistant, Expense	1,000.00
Stenographic and Clerical Salaries	32,780.00
President, Expense	1,200.00
President-Elect, Expense	500.00
Council, Expense	4,000.00
American Medical Association Delegates	5,000.00
Department of Public Relations ($37,200.00):	
Director, Salary	14,000.00
Director, Expense	2,000.00
Asst. Director, Salary	9,500.00
Asst. Director, Expense	2,000.00
Exhibits and Newspaper Publicity	1,000.00
Literature	3,000.00
Postage	2,000.00
Supplies	500.00
Miscellaneous Activities	3,200.00
Committee on Education	250.00
Judicial and Professional Relations Committee	400.00
Committee on Public Relations and Economics	1,000.00
Committee on Scientific Work	750.00
Committee on Auditing and Appropriations and Bookkeeping	850.00
Committee on Blood Banks	200.00
Committee on Chronic Illness	750.00
Committee on Government Medical Service	500.00
Committee on Hospital Relations	400.00
Committee on Industrial Health	500.00
Committee on Maternal Health	1,500.00
Military Advisory Committee ($3,500.00)	
Chairman, Salary	3,000.00
Committee, Expense	500.00
Miscellaneous Committees	500.00
Committee on Rural Health	5,500.00
Rural Medical Scholarships	2,000.00
Committee on School Health	2,000.00
Committee on Veterans' Affairs	500.00
Annual Meeting	22,000.00
Conference of County Society Presidents-Secretaries	1,500.00
Employees Retirement Fund	4,392.93
Insurance and Bonding	3,000.00
Postage	2,000.00
Professional Relations Activities	6,500.00
Rent and Utilities	9,075.00
Stationery and Supplies	3,500.00
Telephone and Telegraph	3,500.00
Legal Expense	7,000.00
Library	500.00
Emergency and Equipment Fund	6,952.40
	$239,200.00

The following specific recommendation of the committee with regard to future planning was officially approved by The Council:

That a building fund be started by setting aside $10,000.00 from the general funds of the Association; that the fund be set up in such a way that it can receive gifts and bequests, such gifts and bequests to be tax deductible; that a special committee be appointed by the President to be known as "The Future Planning Committee" to handle this and similar projects.

ANNUAL MEETING

The Executive Secretary reported on the progress of plans for the 1957 Annual Meeting, Columbus, May 14, 15, 16. He presented to each member of The Council a schedule of events for the three days and stated that a large portion of the program material is now in the hands of the Columbus office.

The Council, by official action, set the date for the Annual Conference of County Society Officers and Committee Chairmen, **selecting Sunday, February 24.** The conference will be held at the Deshler-Hilton Hotel.

BOLINGER CASE

The Council then considered the following letter from Dr. C. E. Bolinger, Marysville:

> "I am advised by letter dated August 1, 1956 from E. J. Holman, Executive Secretary of the Judicial Council of the AMA that transcripts of the records submitted by the OSMA and I presume other evidence have been returned to your association following the Chicago hearing.
>
> "In anticipation of an appeal from the decision of the Judicial Council of the AMA rendered on April 27, 1956, I am requesting that all evidence submitted by myself or by my attorney(s) be returned.
>
> "I consider 'all loose pieces of paper' (quoting Wayne Stichter) as evidence purportedly received and considered by the OSMA.
>
> "I further request your opinion as to whether or not our petition of appeal for re-hearing should be directed to the OSMA or to the UCMS.
>
> "The opinions rendered indicate that certain questions of fact could not be reviewed on appeal and for that reason we are desirous of a re-hearing in that forum which permits such a review.
>
> "If it is the opinion of your Committee on Judicial Relations and the Council of the OSMA that I am foreclosed from a review or re-hearing on questions of fact—we must then obviously resort to the courts of law or equity for a just disposition of these questions of fact."

After discussion, The Council, by official action, instructed the Executive Secretary to reply to Doctor Bolinger as follows:

> "This letter is in reply to yours dated November 1, 1956, and received at this office on November 9, 1956.
>
> "The decision and order of The Council of the Ohio State Medical Association, rendered

December 11, 1955, having been affirmed by the Judicial Council of the American Medical Association, any request for a re-hearing of your case which you propose to make, should, in the opinion of The Council of this Association, be filed with the Judicial Council of the American Medical Association.

"In all appeals in disciplinary matters, the record filed with The Council of the Ohio State Medical Association in connection with the appeal, including the transcript of the evidence and the exhibits in the case, becomes a part of the permanent records of this Association. Consequently your request of November 1, 1956, for delivery to you of certain of these exhibits must be refused."

A letter from Dr. Walter R. Burt, Milford Center, Secretary of the Union County Medical Society, referring to a newspaper advertisement by Dr. C. E. Bolinger during the recent general election, was considered. The advertisement by Dr. Bolinger, who was a candidate for coroner, carried certain statements concerning his opponent and concerning a Columbus physician. Dr. Burt's letter requested that the matter be considered on the basis of whether or not it was a violation of professional ethics.

After discussion, The Council, by official action, instructed the Executive Secretary to advise Dr. Burt that the question he referred to falls within the jurisdiction, in the first instance, of the Union County Medical Society and that it would be the responsibility of that society to take action if the society deemed it advisable or feasible.

MEDICARE PROGRAM

Doctors Meiling and Martin, Mr. Nelson and Mr. Saville presented verbal reports on the status of the Medicare program.

Communications from Dr. Tom Lewis, President of the Ohio State Surgical Association, and the Marion Academy of Medicine, congratulating the Ohio State Medical Association on its stand on this matter, were read.

The Executive Secretary was instructed to clarify statements made by the Government regarding the schedule of allowance in which it was erroneously inferred that the schedule of allowance had been officially agreed to by the OSMA by some formal action or contract.

NEW COMMITTEE NAMED

At this point President Meiling suggested to The Council that a new committee, to be known as Committee on Government Medical Services, be created and that such a committee could serve in an advisory capacity on the Medicare program. By official action, **The Council authorized** Dr. Meiling to appoint such a committee. He did so, naming the following, who have been serving on the special Medicare Committee, as members of the new Committee on Government Medical Services: Dr. Robert S. Martin, Zanesville, chairman; Dr. Charles L. Hudson, Cleveland; Dr. Frank H. Mayfield, Cincinnati; Dr. E. H. Artman, Chillicothe; Dr. Robert E. Hopkins, Coshocton; and Dr. George W. Petznick, Shaker Heights.

MEDICAL RESEARCH BILL

The Council received a verbal report from the special committee which has been studying the question of possible legislation to secure a greater number of dogs for medical research and teaching in Ohio. The report was presented by Dr. Thomas D. Kinney, Cleveland, chairman of the committee, and Dr. A. C. Corcoran, Cleveland, a member of the committee. They presented data concerning the shortage of dogs for medical research and teaching; pointed out that most of the research institutions and medical schools are in a precarious position with respect to a future supply of dogs and stated that present procurement programs are in general not satisfactory or workable on a long term basis. Dr. Kinney specifically presented to The Council a recommendation of the committee that enabling legislation be presented at the 1957 session of the Ohio General Assembly opening on January 7.

By official action, **The Council instructed the committee to prepare** a bill and to take the proper steps to have it presented to the General Assembly with the sponsorship and active support of the Ohio State Medical Association.

PUBLIC RELATIONS AND ECONOMICS

Mr. Saville presented a report on behalf of the Committee on Public Relations and Economics pertaining to meetings of that committee held on November 3 and 4, 1956. The report was officially **approved** by The Council: *(See page 200 for story on Committee action).*

COMMITTEE REPORTS APPROVED

A report of a meeting of the Committee on School Health, held on October 28, was presented on behalf of the committee by Mr. Page, committee secretary. By official action the report of the committee was approved. *(See page 196 for story on committee activities.)*

Mr. Page also reported on a conference which he and Dr. Shaffer had held with representatives of the Ohio High School Athletic Association on November 2. The outcome of the conference was a proposal for a joint conference on the subject of the effect of competitive, body contact athletics on elementary and junior high school pupils. The Council, by official action, authorized the Committee on School Health to be a participant in such conference if one is arranged by school officials.

A report of the Committee on Rural Health was presented by Mr. Page. It was **approved** by official action. *(See page 197 for story on this committee.)*

MATERNAL HEALTH PROGRAM

Mr. Page reported that the Committee on Maternal Health had held seven meetings during

the calendar year. He reported specifically on the last meeting held on November 18, at which the following actions were taken: Approval of a project whereby committee members agreed to write articles on cases studied for *The Ohio State Medical Journal*; instructed the secretary of the committee to send copies of the Massachusetts Medical Society "Minimum Standards of Obstetric Care" to local Maternal Health Committees in Ohio, requesting comments and suggestions as to the establishing of minimum standards in Ohio; discussed a plan with the Division of Vital Statistics for securing information on each female death in the 15 to 44 age group in Ohio as to whether the deceased had been pregnant during the 365 days preceding death in order to give the committee an additional check on maternal deaths. By official action, the report of the committee was approved.

REPORTS ON DIAGNOSIS

A communication from a county society asking whether it is illegal or unethical for physicians to supply diagnostic data to welfare agencies which are paying medical bills, was discussed. By official action, The Council stated that it did not consider this illegal or unethical; that agencies paying medical bills for others are entitled to essential information of this kind; that the usual provision of confidential communications does not apply in such cases where the patient expects his medical bill to be paid by a third party. The Executive Secretary was instructed to convey this information to the society.

HOSPITAL QUESTION

A letter from a member asking for an opinion on the following question, was read and referred to the Judicial and Professional Relations Committee: "Can the medical staff constitution of a non-profit hospital prevent a physician, duly licensed by the State Medical Board of the State of Ohio, from having staff privileges for the sole reason that he is not a graduate of a medical school of the United States or Canada?"

MEDICAL-LEGAL SYSTEM

A communication from Richard S. Childs, chairman of the Executive Committee, National Municipal League, New York, relative to medical-legal investigative systems and suggesting that study be given to this matter in Ohio, was considered. After discussion, the President was authorized to appoint a committee to secure facts concerning the county coroner system in Ohio and to explore the possibility of legislation to create an improved system of medical-legal investigation in this state.

AMEF PROGRAM

Mr. Saville presented a report on the American Medical Education Foundation program in Ohio for the year 1956. The following facts were reported:

As of November 30 a total of $21,303.25 had been contributed to the American Medical Education Foundation by 430 donors; as compared with $24,432.50 from 388 contributors as of November 30, 1955. The 1956 total did not include a recent contribution of $2000.00 from the Mahoning County Medical Service in memory of the late Dr. Wm. M. Skipp, for several years AMEF chairman in Ohio. This contribution was reported by Dr. Gustafson.

AKRON BEACON JOURNAL COMMENDED

A communication from Dr. Millard C. Beyer, chairman of the Public Relations Committee of the Summit County Medical Society, was read and discussed. The letter referred to the polio prevention month project of that society and the splendid help which the society had received from the *Akron Beacon Journal*, even to the extent of supplying funds to help in the purchase of vaccine for the free clinics. By official action, The Council requested Dr. Meiling to send a letter of commendation on behalf of The Council to the *Akron Beacon Journal*.

MISCELLANEOUS BUSINESS

Doctors Woodhouse and Meiling presented verbal reports on the recent meeting of the House of Delegates of the American Medical Association in Seattle.

A recommendation from the 1956 Ohio Health Commisisoners Conference regarding pediatric-cardiac clinics to be subsidized by the Ohio Department of Health was referred for study to the Committee on Public Relations and Economics.

A recommendation from the 1956 Ohio Health Commissioners Conference favoring some regulations "to register, license or by some system approve or certify medical technologists in Ohio" was referred, together with correspondence from various groups of medical technologists, to the Committee on Public Relations and Economics for study.

A letter from the Ohio Driver Education Association, thanking the OSMA for its financial contribution and cooperation in helping to make the first state-wide Youth Traffic Safety Conference held in Ohio on November 30-December 1 a success, was read and ordered filed.

A letter from the Ashtabula County Medical Society, stating that the society on September 11 voted 14 to 9 in favor of inclusion of physicians under the Social Security program, was read and ordered filed.

President Meiling was authorized to name a nominating committee to present a slate of nominees for the Board of Directors of Ohio Medical Indemnity, Inc., for consideration at the next meeting of The Council.

The Executive Secretary reported that to date reports had been received from only 16 counties

on malpractice cases. By official action, The Council authorized that the present project of collecting information on malpractice cases be discontinued as it has proved impractical and ineffective.

A communication from Dr. Warren W. Smith, regarding the Institute of Medical Physics, Belmont, California, dated November 28, 1956, was discussed. By official action, the Executive Secretary was instructed to refer this file to the Judicial Council of the American Medical Association for consideration and action.

Members of The Council then presented reports on activities in their districts.

There being no further business, The Council adjourned until Saturday, February 23, 2 P. M., when a regular Council meeting will be held.

Attest: CHARLES S. NELSON
Executive Secretary

Cleveland Health Museum Honored On 20th Anniversary

In December the Cleveland Chamber of Commerce held a luncheon in honor of the 20th anniversary of the Cleveland Health Museum. Don Dunham, medical writer for the *Cleveland Press*, in a four-column article described the success of the museum at 8911 Euclid Avenue, in part as follows:

"Tens of thousands of school children from all over Ohio have gone through its halls. Doctors and public officials from all over the world have visited it. It has encouraged similar but smaller museums, even built exhibits for them, in Dallas, Texas; Lankenau Hospital in Philadelphia, and now building at Hinsdale, Ill., sponsored by the Kettering family.

"Under Dr. Winfield G. Doyle, curator of education, it is building 'suitcase exhibits' so the museum can go to the people. Its costs are kept to a minimum by its excellent workshop which builds models for buyers all over the world. Most of its income comes from members and the Prentiss Trust Fund."

AMA Now Has Information on "Home Care" Programs

Because of increased interest among medical societies in organized "home care" programs—such as the one inaugurated by Montefiore Hospital (New York) several years ago—the AMA's Council on Medical Service recently undertook a study of existing programs throughout the country. The new study includes information on the organization, development, financing, medical services provided, and problems encountered in the various home care programs. Any medical society desiring further information should contact the Council.

OSMA Committee on School Health Undertakes Special Projects

Plans for future operations of the Committee on School Health of the Ohio State Medical Association received the endorsement of the Association's Council at its meeting of December 14 - 15.

The Committee was authorized to revise and modernize School Health Guides Nos. 1, 2, and 3, originally published in 1951. The Council also endorsed the development of additional guides on various school health problems.

The development by the Committee of a series of articles on the medical aspects of school health for publication in *The Ohio State Medical Journal* received approval.

Also approved was a resolution of the Committee on School Health, regarding school health records adopted at its October 28 meeting. It reads as follows:

> "The Committee voted to approve the principle of cumulative health record systems for schools, embodying examination and immunization by the family physician; to endorse the record developed by the State Department of Health; to recommend the use of this record as a method of facilitating interchange and interpretation of data among school, family doctor, and parents; and to suggest that the record be re-evaluated from time to time to incorporate those things brought to light by experience."

The Council was also advised of a conference between representatives of the Ohio High School Athletic Association and the Chairman and Secretary of the Committee on School Health regarding mutual problems of school health, in accordance with an action of the Committee on October 28.

The Council authorized the Committee on School Health to participate in a contemplated conference with the Ohio Association for Health, Physical Education and Recreation; high school and elementary principals and superintendents, recreation directors; the State Planning Committee on Health Education; and the Ohio High School Athletic Association regarding the study of mental and physical effects of competitive, body-contact athletics in elementary and junior high schools.

Chairman of the Committee on School Health is Dr. Thomas E. Shaffer of Columbus.

American College of Surgeons Offers Fracture Course

An intensive course on fractures and other trauma will be offered to all interested members of the medical profession by the Chicago Regional Committee on Trauma of the American College of Surgeons. The course will be held from April 10 to 13, 1957, at the John B. Murphy Auditorium, 50 East Erie Street, Chicago.

Rural Health Activities . . .

Projects Sponsored by Committee, Including Preceptorship Plan, Extension of Lectures, 4-H Club Program, Approved by Council

SEVERAL newly developed projects of the Ohio State Medical Association's Committee on Rural Health received approval when The Council met in Columbus, December 14 - 15.

The Committee was given authority to establish a limited preceptorship plan for medical students between the junior and senior years at the University of Cincinnati College of Medicine. The preceptorship will be sponsored by the Committee with the cooperation of the School of Medicine, and will be offered the last two weeks of June.

Also authorized was the contemplated extension of the OSMA series of lectures on family or general practice to the Western Reserve University School of Medicine, under the sponsorship of the Committee and with the cooperation of the School of Medicine.

4-H CLUBS PROGRAM

A five-point program of lending assistance to the Health Program of the 4-H Clubs in Ohio was submitted by the Committee and was endorsed by The Council.

The plan includes helping with the simplification and standardization of the physical examination forms now used in the 4-H Health Improvement Contest; and the development by the Committee of a special individual health history record booklet to be kept by 4-H Club members as a part of their activities in the Health Improvement Contest.

In addition, the Council approved the Committee's suggestion that the Ohio State Medical Association sponsor each year the State Boy's Health Recognition award, which involves a trip to the National 4-H Club Contest.

As recognition to the winners of the county 4-H Club Health Improvement Contests it was decided to award to both boy and girl winners a one-year subscription to *Today's Health*, along with an appropriate letter of congratulations.

It was the opinion of The Council that the Committee should continue to assist with the judging of the State 4-H Club Health Improvement Contest.

CONFERENCE WITH FARM LEADERS

The Committee also reported that it had met with members of the OSMA Rural Medical Scholarship Advisory Committee on November 14; that the plans and activities of the Committee had the general approval of the farm leaders, and that there was mutual appreciation of the willingness of both groups to work in harmony to solve problems of rural health.

Advisory Committee members present were: H. D. Heckathorn, Forest, President of the Ohio Farm Bureau Federation; Mrs. Litta K. Roberson, Director of Women's Activities of the Ohio Farm Bureau Federation; H. W. Harshfield, State 4-H Club Leader; William Zipf, Farm Editor of *The Columbus Dispatch;* A. W. Short, Supervisor, Conservation Education, Departments of Education and Natural Resources; and A. W. Orcutt, Rural Sociologist, Agricultural Extension Service, OSU. The following Advisory Committee members sent regrets that they were unable to attend due to conflicting meetings: W. B. Wood, Director, Agricultural Extension Service, OSU; Earl W. McMunn, Editor of *The Ohio Farmer;* Byron Frederick, Master of the Ohio State Grange; and R. Bruce Tom, Health Chairman of the Ohio State Grange.

Chairman of the Committee on Rural Health is Dr. Edmond K. Yantes of Wilmington.

Deadline for Getting Special Auto Tags is February 15

Members of the Ohio medical profession who desire 1957 automobile license plates bearing the word "Physician" have until Feb. 15 to have their applications for the special tags in the hands of the Bureau of Motor Vehicles, Columbus 16, Ohio.

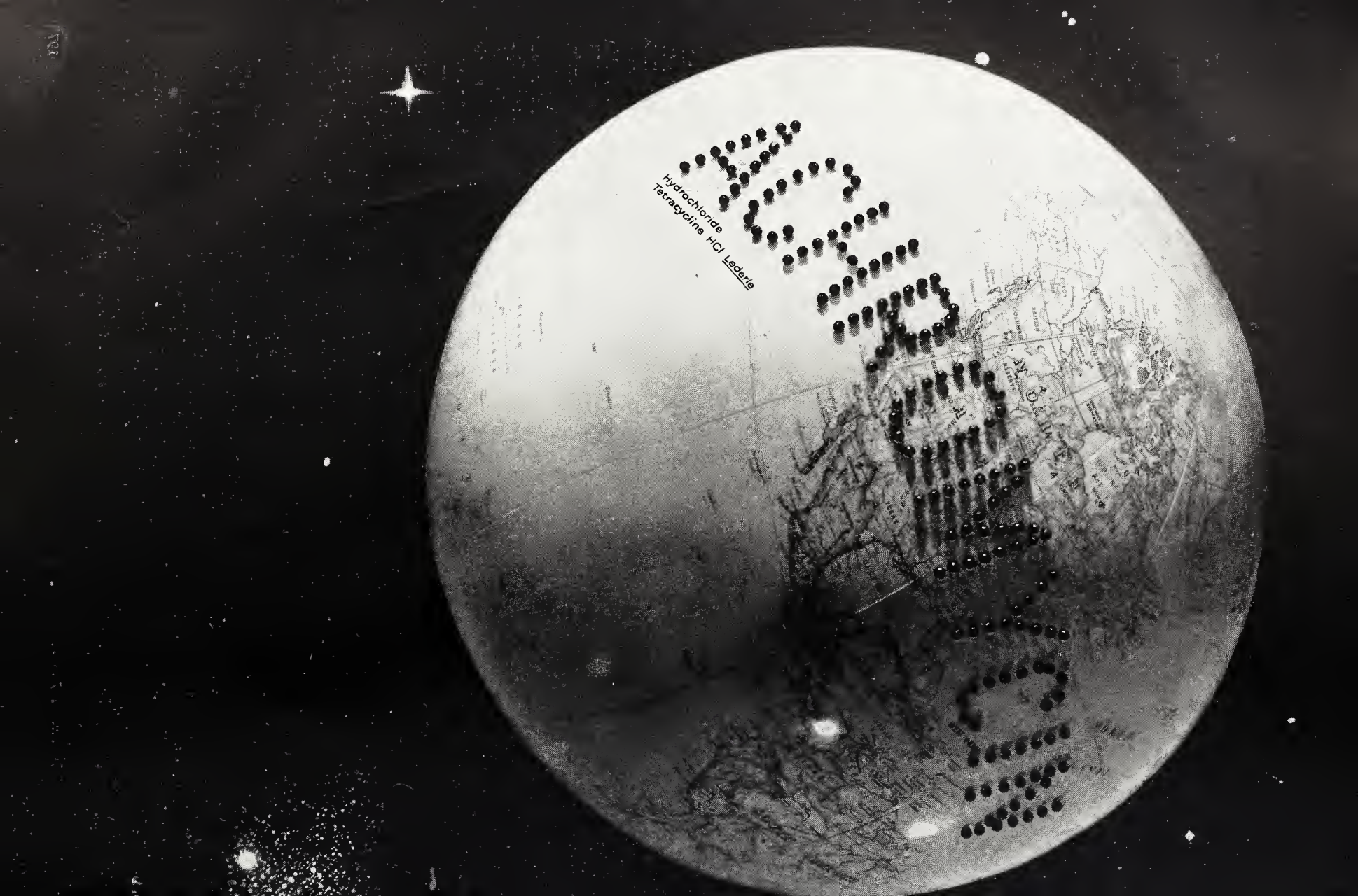
Physicians who had the special tags in 1956 were mailed applications for 1957 plates during December by the Motor Vehicle Bureau.

Although a state law provides a physician may obtain such tags if he so desires, **there is nothing in the law that makes it compulsory.**

Some physicians feel the tags are a special invitation for narcotics addicts and thieves to loot the doctor's car, and that they attract undue attention and involve the doctor in nuisance types of cases.

Ohio physicians who may want to obtain the tags for the first time in 1957 should write to the Bureau of Motor Vehicles for application forms. One of these forms is a certification of medical licensure which the physician must have executed and signed by the Ohio State Medical Board, 21 W. Broad St., Columbus.

The Bureau of Motor Vehicles also emphasized that the vehicle for which the license plates are used must be registered in the name of and the application must be in the name of the physician who obtains the plates. This requirement means that the Ohio State Medical Association Headquarters cannot process such applications since the Bureau requires that the physician apply directly to the Bureau.


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P. R. Committee Meets . . .

Matters Relating to Insurance Forms, OMI Anesthesia Coverage Policy, Diabetes Detection Program Acted On; Approved by The Council

A DETAILED report on actions taken at a meeting of the Committee on Public Relations and Economics on November 3-4 in the Columbus office was presented to The Council during its meeting, December 14-15.

The Council officially approved the committee's actions and recommendations, a digest of which follows:

SIMPLIFIED INSURANCE FORMS

Pursuant to the instructions of The Council at its September 14-15 meeting, the Committee reconsidered its action of June 3, recommending a simplified insurance form for use in Ohio. This action resulted from a request from the Health Insurance Council, representatives of which attended the meeting.

Representatives of the Health Insurance Council stated that they are cognizant of the problems of the medical profession in regard to claim forms. They related the history of the negotiations between the Health Insurance Council and the Council on Medical Service of the AMA, which resulted in the standardized forms now being offered to insurance companies throughout the country. It was stated that a survey is now being made to determine just how many of the insurance companies are willing to adopt the standardized forms.

CITE THEIR OBJECTIONS

The representatives of HIC stated specific objections to the simplified form, which had previously been approved by the Committee. It was stated that the form was inadequate for use in a death case; that there should be a provision for noting the age of the claimant for purposes of identification and processing of claims which have an age differential clause. Other suggestions were that the word "approximate" should be deleted from the item "Approximate period of disability"; also, the use of the word "probable" in the item "Probable date of onset" was questioned. Objection was expressed to the item "Operation, if any—(type and date)." It was felt that this would result in inadequate descriptions of the operative procedure. It was suggested that this be changed to "Nature of surgical or obstetrical procedure, if any—(describe fully)—date."

SAY LOCAL FORMS ACCEPTED

There was a general discussion as to how far the insurance company should expect the physicians to go in furnishing information that would enable them to adjudicate claims. Some members of the Committee felt that some insurance companies ask the physicians to furnish information which the insurance companies should ascertain for themselves through investigation.

Mr. Edward F. Willenborg, Executive Secretary of the Cincinnati Academy of Medicine, and Mr. M. John Hanni, Jr., Executive Secretary of the Cleveland Academy of Medicine, reported that most insurance companies were accepting the forms developed by their Academies. A similar report was received by letter from Mr. Robert W. Elwell, Executive Secretary of the Toledo Academy of Medicine, and Mr. E. M. Sprunger, Executive Secretary of the Stark County Medical Society.

AGREED TO SEND DATA

It was agreed that the representatives of HIC present would send to the Committee memoranda listing specifically their objections to the simplified form previously approved by the Committee and The Council; that the Committee would be supplied with samples of claim forms now being used by major insurance companies; and with the results of the survey now being conducted of the number of insurance companies which have adopted the standardized forms recommended by HIC and the AMA.

Pending the receipt of this information from the HIC, the Committee voted that implementation of the previous action approving a simplified insurance form for use in Ohio be postponed until after further negotiations with the HIC.

OMI ANESTHESIA COVERAGE

The Committee considered the following resolution adopted by the Ohio Society of Anesthesiologists, referred by The Council for a conference with representatives of the Ohio Society of Anesthesiologists and the Ohio Medical Indemnity, Inc.:

"WHEREAS the administration of anesthesia is recognized as an integral part of the practice of medicine, and

"WHEREAS the American Medical Association has long recognized the status of Anesthesiology by the acceptance of a Section on Anesthesiology in the American Medical Association, and

"WHEREAS the Ohio Medical Indemnity Plan (the Doctors' Plan) was evolved a number of years ago to pay for medical services rendered by doctors, and

"WHEREAS Ohio Medical Indemnity, Inc., formulated a new contract in which payment for the administration of anesthesia is included even though such services are rendered by persons other than doctors, and

"WHEREAS such coverage is contrary to

the original concept of the Doctors' Plan, and gives tacit approval to the private practice of medicine (anesthesiology) by persons other than doctors, and

"WHEREAS no distinction is made between the service rendered by a physician and a non-physician, and

"WHEREAS such approval by the Ohio Medical Indemnity, Inc. and by the Ohio State Medical Association will tend to create, in many communities in the State of Ohio, a situation which will discourage the trained anesthesiologist from entering into practice in the community, and

"WHEREAS this will tend to reduce the quality of medical care in the communities of Ohio, and be a detriment to the progress of scientific medicine in the State of Ohio.

"THEREFORE, BE IT RESOLVED that the Ohio Society of Anesthesiologists, in the interest of providing progressively better medical care to the people of Ohio, is opposed to this action of Ohio Medical Indemnity, Inc., and

"THEREFORE, BE IT FURTHER RESOLVED that the Ohio Society of Anesthesiologists ask the Ohio State Medical Association to request the Ohio Medical Indemnity, Inc., to revise Article I, Section 8, paragraph B, in the new contract."

PROS AND CONS DISCUSSED

Dr. Jay J. Jacoby, President of the Ohio Society of Anesthesiologists, and other representatives, appeared to discuss the resolution. Dr. Jacoby stated that in his opinion the present shortage of physician-anesthesiologists would be solved within a few years because more physicians are completing training in this specialty annually.

Some representatives of the anesthesiologists' society objected to OMI indemnifying non-physicians for anesthesia because OMI is "The Doctors' Plan" and is sponsored by the OSMA.

It was pointed out that OMI was organized to provide indemnity to its subscribers against medical and surgical expenses and that nothing is said in the purpose clause of OMI that indemnities should be paid only for services of doctors of medicine. After a full discussion the Committee by unanimous vote adopted the following statement:

ACTION OF COMMITTEE

"It is the feeling of the Committee that the desirability of physician-administered anesthesia is evident and should be strongly fostered, but it does not see how Ohio Medical Indemnity, Inc., can refuse to indemnify subscribers for any anesthesia legally given. It is the hope of the Committee that the present shortage of physician-anesthesiologists will soon be alleviated."

DIABETES DETECTION PROGRAM

The Committee studied a proposed diabetes detection program of the Ohio Department of Health, referred to the Committee by The Council. Dr. Frederick H. Wentworth, Acting Chief of the Division of Chronic Diseases, Ohio Department of Health, outlined the proposed program.

The objectives of the proposal would be to find by the application of screening techniques individuals with obvious or suspected abnormalities of glucose metabolism and to refer them to their private physicians for definitive diagnosis and therapy, if indicated. It was proposed that the Ohio Department of Health actively engage in stimulating the institution of case-finding programs at the local level. The Department would provide equipment and personnel for use locally in much the same manner as they now provide them in venereal disease and tuberculosis control. Each proposed local project would be presented to the local medical society for its approval.

Dr. Wentworth stated that this type of diabetes case-finding is now being done in Florida, Virginia and West Virginia. He emphasized that the Ohio Department of Health would not participate in the development of a diabetes case-finding program in any locality before the program had first been presented to and approved by the local medical society.

ACTION OF COMMITTEE

Members of the Committee queried Dr. Wentworth at length concerning various aspects of the program. Following an extended discussion, the Committee unanimously adopted the following statement for consideration by The Council:

"The desirability of early recognition of disease in general is recognized. However, the philosophic concept of governmental case-finding of a non-communicable, non-industrial, naturally-occurring disease, the cost per case of those found, and the chances of favorably influencing the ultimate outcome of the disease are questionable to the extent that the Committee does not approve of the project.

"Since a pilot study is under way in one Ohio county, with the approval of the county medical society, it may become desirable to reconsider the subject in light of the findings in that county."

GROUP MALPRACTICE INSURANCE

The question of the possibility of group malpractice insurance for members of the Association was then discussed. It was the feeling of members of the Committee that nothing further should be done on this subject until the Legal Department of the American Medical Association has completed a comprehensive nationwide study of the malpractice insurance problem. It was reported that this study is now being made, and that results of the study would be made available to state medical societies.

THOSE IN ATTENDANCE

The following members of the Committee on Public Relations and Economics were present: Dr. Frederick P. Osgood, Toledo, Chairman; Dr. John

H. Budd, Cleveland; Dr. John A. Fraser, East Liverpool; Dr. Horace B. Davidson, Columbus; Dr. J. Robert Hudson, Cincinnati; and Dr. Robert S. Martin, Zanesville, the President-Elect.

Others in attendance were: Dr. Frederick H. Wentworth, Acting Chief of the Division of Chronic Diseases, Ohio Department of Health.

Representatives of the Health Insurance Council—Mr. Howard LeClair, Vice-President, Mutual Benefit Health and Accident Association, and Chairman of Uniform Forms Committee, HIC; Mr. W. G. Alpaugh, Jr., Vice-President, Inter-Ocean Insurance Company, and Chairman of HIC Ohio Committee; Mr. E. W. Sours, Assistant Secretary, Casualty Claims Department, Aetna Life Insurance Company; Thomas F. Ross, M. D., Medical Director, Ohio State Life Insurance Company, and member of HIC Ohio Committee; Mr. Albert V. Whitehall, Associate Director of Health Insurance, Life Insurance Association of America; and Mr. Richard J. Eales, Assistant Director of Health Insurance, LIAA.

Representatives of the Ohio Society of Anesthesiologists—Dr. Jay J. Jacoby, Columbus, President; Dr. A. William Friend, Akron; Dr. L. E. Larrick, Cincinnati; Dr. A. L. Schwartz, Cincinnati; Dr. George F. Collins, Columbus; Dr. James P. Curran, Dayton; Dr. William Hamelberg, Jr., Columbus; and Dr. John C. Stahler, Dayton.

Representatives of Ohio Medical Indemnity, Inc.—Dr. H. M. Clodfelter, Columbus, member of the Board of Directors of the OMI, and Mr. Frank W. Van Holte, Columbus, Assistant Treasurer.

Also in attendance were: Mr Howard O. Brower, Assistant Secretary, Council on Medical Service, American Medical Association; Mr. Edward F. Willenborg, Executive Secretary, Cincinnati Academy of Medicine; Mr. Robert F. Freeman, Executive Secretary, Montgomery County Medical Society; Mr. M. John Hanni, Jr., Executive Secretary, Cleveland Academy of Medicine; and Messrs. Nelson, Saville, Page, Moore and Edgar of the OSMA Headquarters Office.

Fourth and Fifth Child in Family Becoming More Common in U. S.

Families are becoming larger in the United States. This is evidenced by an increasing number of couples now having a third or fourth child. The annual rate for third births has climbed from 1.8 per 100 married women under age 45 in 1940-41 to 3.1 per 100 in 1954-55. For fourth births, the rate increased by 70 per cent during this period.

Fifth and subsequent births also increased somewhat in recent years and are likely to continue upward for the balance of the decade.—*Metropolitan Life.*

Ohio State University Offers Course in Ophthalmology

The Department of Ophthalmology at Ohio State University is offering a two-day postgraduate course in ophthalmology on Monday and Tuesday, March 5 and 6. The program will be held in the Conference Theater, Ohio Union Building, High Street at 13th Avenue on the OSU campus. Registration fee is $20. Inquiries should be directed to William H. Havener, M. D., Department of Ophthalmology, University Hospital, Columbus 10, Ohio.

The program has been announced as follows:

MONDAY MORNING, MARCH 4

Moderator: Dr. James M. Andrew, OSU.

Clinical Use of Steroids, Dr. Geo. J. Hamwi, OSU.

Recent Advances in the Diagnosis and Treatment of Glaucoma, Dr. Alfred E. Maumenee, Johns Hopkins University.

Evaluation of Headache, Dr. William E. Hunt, OSU.

MONDAY AFTERNOON

General Anesthesia in Eye Surgery, Dr. Jay Jacoby, OSU.

Surgery of the Conjunctiva and Cornea, Dr. Maumenee.

Diagnosis and Care of Muscle Pareses, Dr. Francis H. Adler, University of Pennsylvania.

Refreshments followed by a dinner meeting with the Columbus Academy of EENT.

Evening Program: **Diagnosis and Management of Uveitis**, Dr. Maumenee.

TUESDAY MORNING, MARCH 5

Slit Lamp Movie—Berliner.

Diagnosis and Care of Muscle Pareses, Dr. Adler.

Ophthalmologic Diagnosis of Intracranial Aneurysms, Dr. John W. Henderson, University of Michigan.

TUESDAY AFTERNOON

Diagnosis and Care of Muscle Pareses, Dr. Adler.

Neuro-Ophthalmologic Syndromes, Dr. Henderson.

Practical Ocular Microbiology, Ted Suie, Ph. D., OSU.

Differentiation of Optic Neuropathies, Dr. Henderson.

Orthopedic Surgery Is Subject In World War II Series

The eighth publication in the Army Medical Service's clinical series on World War II, *Orthopedic Surgery in the European Theater of Operations*, is now off the press. It may be obtained from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at a cost of $4.00.

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

Six physicians are serving in the House of the 85th Congress. They are Drs. Walter H. Judd, Minnesota, member of House since 1942; Arthur L. Miller, Nebraska, member since 1942; Ivor D. Fenton, Pennsylvania, member since 1939; Thomas F. Morgan, Pennsylvania, member since 1944; Will E. Neal, West Virginia, 1952-54 and elected again for 1957-58, and Antonio Fernos-Isern, Puerto Rico, non-voting member who has served previously in House several times.

* * *

The United States had 22,510,000 veterans in civilian life as of September 31, 1956, compared with 22,009,000 as of September 31, 1955, according to federal statistics.

* * *

Electric and insulin shock treatment for mental illness have been reduced by an estimated 90 per cent at Veterans Administration mental hospitals through use of the new tranquilizing drugs, according to the VA, and more patients are being returned home via discharge or trial visits, VA reports.

* * *

The American Medical Association Council on Medical Education has approved a two-year residency program in general practice at the Fort Knox, Ky., U. S. Army Hospital. It is the only general practice residency program conducted by the Army Medical Service. First year is devoted to medicine and medical sub-specialities, including six months in pediatrics; the second, to surgery and surgical sub-specialities, including six months in gynecology and obstetrics.

* * *

Public Health Service began testing questionnaire prepared for National Health Survey with trial run at Charlotte, N. C., January 28. Sample of urban home residents was interviewed to collect statistics on number, age, sex and occupation of persons suffering from diseases, injuries or handicapping conditions; medical care received, time away from work or other activities, and economic and other impacts. Survey on national scale may begin in May. Only statistical totals will be published.

* * *

National Heart Institute has made largest grant of its kind in the institute's history, $575,000 to director of research of American Heart Association to evaluate effectiveness of drugs in treating heart disease. Purpose is to provide basis for testing program for new drugs on broad scale. Initial study will be hypertension.

Food and Drug Administration has under way continuous study of radioactivity in selected staple foods. Background radioactivity is determined and then foods are monitored for changes.

* * *

Congress may investigate VA hospital admission procedures for non-service-connected disabilities. Probe into whole GI program is expected. Veterans who get free hospital or dental treatment by falsifying ability to pay will constitute one target.

* * *

The President's Committee for Traffic Safety has announced release of eight new films which explain the importance of the Action Program to reduce traffic accidents. Purpose of the Action Program is to map out exactly how everyone, including physicians, can effectively support a well-planned drive to reduce traffic accidents. The films and a descriptive folder can be obtained from the President's Committee for Traffic Safety, General Services Building, Washington 25, D. C.

* * *

Money for medical research is expected to be major health item in Federal budget. If recent pattern is followed, Congress will vote even bigger sums than administration asks. However, some members of Congress, including key members of House Appropriations Committee, question whether there are enough qualified medical researchers to make good use of the huge appropriations.

* * *

Polio cases during 1956 totalled about 15,000, unofficial figures at USPHS show, a nine-year low and just a little more than one-half of cases reported in 1955.

* * *

Robert H. Hamlin, M. D., former resident of Columbus, Ohio; for several years public health director of Brookline, Mass.; Harvard University law and public health facultyman, will join the staff of H.E.W. Director Marion B. Folsom as an advisor on basic legislative policy.

* * *

It is rumored the Veterans Administration will start a policy of giving fee-basis physicians in the home-town-care program, authorizations to continue treatments for periods up to one year instead of month-by-month and will permit the doctors to submit bills on their regular letterheads instead of on VA forms.



Mark These Dates

On Your Calendar . . . and . . .

Make Hotel Reservations Now

For the 1957 ANNUAL MEETING of the OHIO STATE MEDICAL ASSOCIATION. The place is COLUMBUS: the dates, MAY 14, 15 and 16, 1957.

Here is a list of leading downtown Columbus hotels and a hotel reservation blank for convenient mailing.

NAME AND LOCATION	SINGLE	DOUBLE	TWIN
NEIL HOUSE, 41 S. High St.	$ 6.00-11.00	$ 9.00-11.00	$11.00-14.00
DESHLER-HILTON HOTEL, W. Broad & N. High	$ 5.00-13.50	$11.00-18.50	$11.00-18.50
FORT HAYES HOTEL, 31 W. Spring St.		$ 9.00 up	$ 9.00 up
SENECA HOTEL, 361 E. Broad St.	$ 4.00- 7.00	$ 6.00- 9.00	$ 9.00-12.00
HOTEL SOUTHERN, S. High & E. Main Sts.		$ 8.00 up	$ 9.00 up
VIRGINIA HOTEL, Gay & Third Sts.	$ 7.00- 8.00	$10.00-12.00	$11.00-14.00

Persons who desire additional accommodations are advised to specify their needs to the hotel of choice.
(All Rates Subject to Change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager ..... Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 14, 15, 16, 1957, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....

☐ Twin Bed Room with Bath ☐ Other

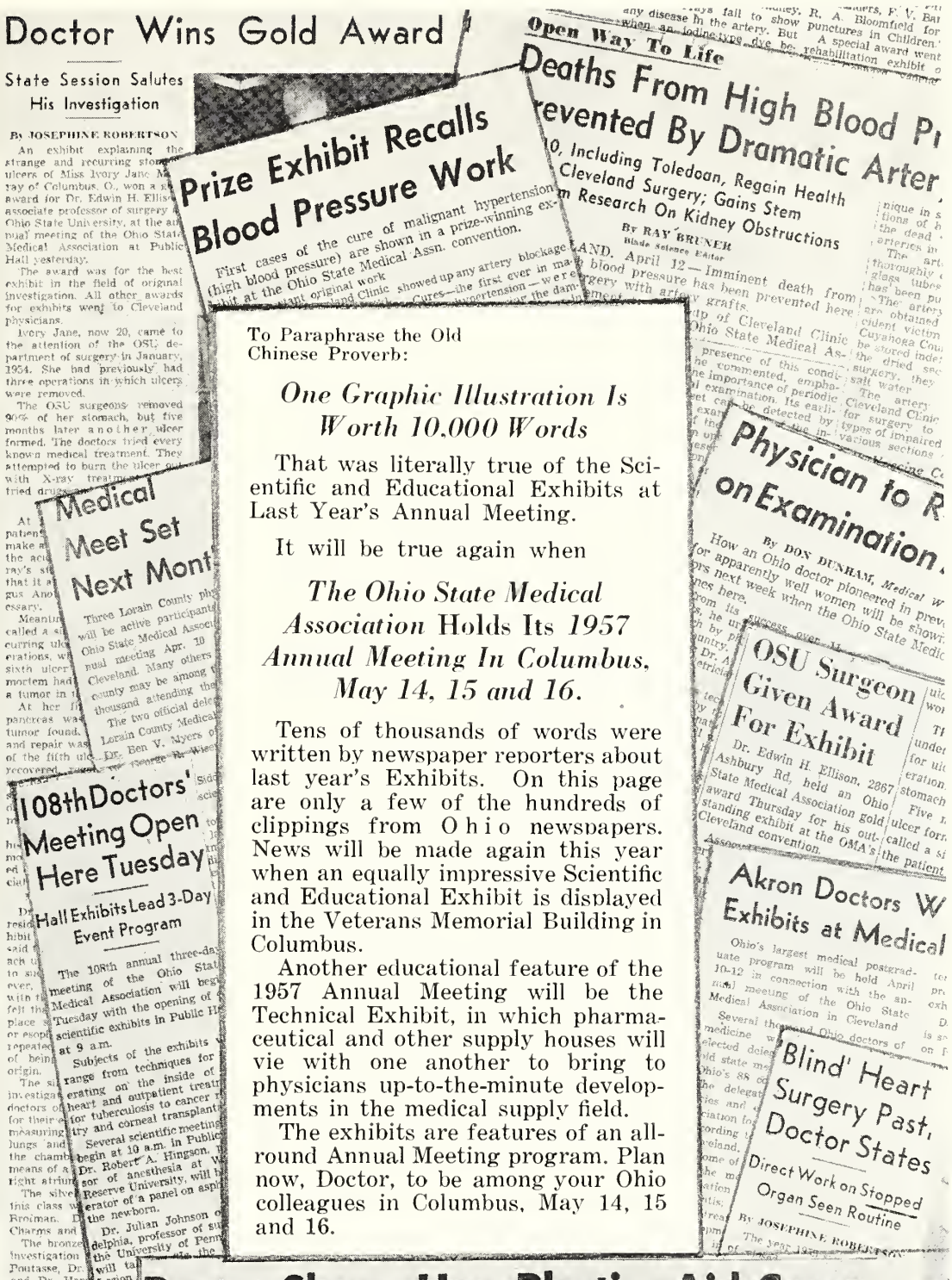
Arriving May at A. M. P. M.

PLEASE VERIFY MY RESERVATION

Name .....

Address .....

.....



To Paraphrase the Old Chinese Proverb:

One Graphic Illustration Is Worth 10,000 Words

That was literally true of the Scientific and Educational Exhibits at Last Year's Annual Meeting.

It will be true again when

The Ohio State Medical Association Holds Its *1957 Annual Meeting In Columbus, May 14, 15 and 16.*

Tens of thousands of words were written by newspaper reporters about last year's Exhibits. On this page are only a few of the hundreds of clippings from Ohio newspapers. News will be made again this year when an equally impressive Scientific and Educational Exhibit is displayed in the Veterans Memorial Building in Columbus.

Another educational feature of the 1957 Annual Meeting will be the Technical Exhibit, in which pharmaceutical and other supply houses will vie with one another to bring to physicians up-to-the-minute developments in the medical supply field.

The exhibits are features of an all-round Annual Meeting program. Plan now, Doctor, to be among your Ohio colleagues in Columbus, May 14, 15 and 16.

Conference of County Society Officers . . .

The Doctors' Stake in Legislation, Teamwork Between County Society And the Press Are Among Topics for Invitational Meeting in Columbus

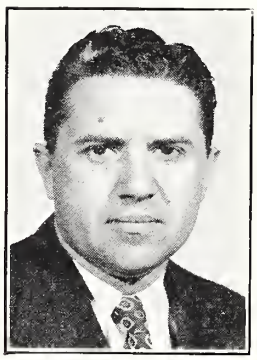
THE annual Conference of County Medical Society Officers and Committeemen with officers of the Ohio State Medical Association will be held in the Deshler-Hilton Hotel, Columbus, on Sunday, February 24. This is an invitational meting.

Guest speakers will include Dr. Thomas H. Alphin, director of the Washington Office of the American Medical Association, who will discuss the U. S. Congress—health and medical bills before Congress, the part doctors play in contacts with their Congressmen, etc.

Dr. Alphin knows the Washington scene from experience. He first became associated with the Washington Office in 1953 as assistant director, later accepting a post as assistant dean of the Faculty of Medicine at the University of Missouri



T. H. ALPHIN, M. D.



LOREN SCHULTZ

and returning to the Washington Office as deputy director in 1955. He was made director in November, 1955.

Before his association with the Office, he was with the Federal Civil Defense Administration, first as regional medical officer and later as national chemical warfare defense officer. A graduate of the University of Virginia Medical Department in 1947, he has held several teaching appointments.

"Teamwork Between the County Medical Society and the Press," is a timely subject that will be discussed by Loren G. Schultz, city editor of the *Springfield Daily News*. Mr. Schultz is a practical newspaperman and as city editor it is his responsibility to supervise the digging out of local news for his publication. A graduate of the State University of Iowa, Class of '40, he did practical newspaper work while attending college. Before going to Springfield in 1942, he was city editor of the *Iowa City Press-Citizen*.

Those invited to attend this conference are the following: Presidents of County Medical Societies, vice-presidents and presidents-elect; secretaries and treasurers, executive secretaries, chairmen of Legislative Committees and delegates to the OSMA; members of The Council of the OSMA, members of the OSMA Committee on Public Relations and Economics, members of the OSMA Committee on Legislation and AMA delegates.

The program is as follows:

MORNING PROGRAM

DESHLER-HILTON BALLROOM

9:00 A. M. Registration

9:30 A. M. Introductory remarks by RICHARD L. MEILING, *M. D., President*, Ohio State Medical Association, chairman of Morning Session.

9:45 A. M. "HINTS AND HUNCHES FOR COUNTY SOCIETY PRESIDENTS AND SECRETARIES"

MR. HART F. PAGE, *Assistant Director* of Public Relations and administrative assistant, Ohio State Medical Association.

(Suggestions on the mechanics of County Medical Society activities; committee work; improving contacts between the County Medical Society and the Columbus Office of the OSMA.)

10:15 A. M. QUESTIONS AND ANSWERS.

10:30 A. M. Coffee Break

10:45 A. M. "THE MEDICARE PROGRAM"

CHARLES L. HUDSON, M. D., Cleveland, *Immediate Past-President*, Ohio State Medical Association.

(Dr. Hudson will present a brief history of the Federal Medical Care Program for Military Dependents which became effective last December 7; review the policy actions taken by The Council on the program and the reasons for such actions. During this period and the Question and Answer period which follows, up-to-date information an administrative rules and regulations, forms, fees, etc., will be presented.)

11:15 A. M. QUESTIONS AND ANSWERS.

11:30 A. M. "CASE OF THE DOUBTING DOCTOR."

Motion picture produced by the American Medical Association.

(This is a dramatic film which brings home

in positive fashion the tremendous values of medical societies—County Medical Society, OSMA, AMA. It clarifies the misunderstandings some members have about their societies. It can be booked for showing before any County Medical Society, on request.)

12:00 Noon ELEVEN DISTRICT COUNCILOR CONFERENCES (places to be announced.) (Opportunity for all present to meet and get better acquainted with their Councilor; discuss district and local problems; formulate questions to be presented and Q & A periods in afternoon.)

12:45 P. M. Intermission

AFTERNOON PROGRAM

DESHLER-HILTON BALLROOM

1:00 P. M. COMPLIMENTARY LUNCHEON (All receiving invitations who plan to attend the conference should make a reservation with the Columbus Office to assist it in planning the luncheon.)

Presiding at Afternoon Session: ROBERT S. MARTIN, M. D., *President-Elect*, Ohio State Medical Association.

2:00 P. M. "TEAMWORK BETWEEN THE COUNTY MEDICAL SOCIETY AND THE PRESS," MR. LOREN G. SCHULTZ, Springfield, *News Editor*, Springfield Daily News.

(Mr. Schultz will discuss medical subjects and events which the newspapers believe are important news and on which stories should be carried. Also, he'll suggest ways as to how the local medical society can work with the press in securing and printing news on local medical and health happenings.)

2.30 P. M. QUESTIONS AND ANSWERS

2:45 P. M. "THE DOCTORS' STAKE IN LEGISLATION"

U. S. Congress—THOMAS H. ALPHIN, M. D., *Director*, Washington Office, American Medical Association.

Ohio General Assembly—MR. GEORGE H. SAVILLE, *Director of Public Relations and Assistant Executive Secretary*, Ohio State Medical Association.

(Dr. Alphin and Mr. Saville will review important proposals before Congress and the Ohio Legislature; discuss official policies on many of them; recommend steps for County Medical Societies to take in legislative activities; stress the importance of action by individual physicians in presenting their views to members of Congress and the General Assembly.)

3:45 P. M. QUESTIONS AND ANSWERS.

4:00 P. M. Adjournment.

Several Physicians Are Named on Governor's Advisory Council On Atomic Energy

In response to a resolution adopted at the Governor's Conference on Peacetime Uses of Nuclear Energy and Radiation Safety, then-Governor Frank J. Lausche announced appointment of members of the Governor's Advisory Council on Atomic Energy. Dr. Harold L. Yochum, president of Capital University, Columbus, was named chairman of the Executive Council. Stanley M. Andrews, director of personnel and public relations, Bureau of Workmen's Compensation, Columbus, was appointed executive secretary and coordinator for the Council.

Doctors of medicine on the Executive Committee of the Advisory Council are: Dr. Ralph E. Dwork, director of the Ohio Department of Health; Dr. Hymer Friedell, director of the Department of Radiology, Lakeside Hospital, and professor of radiology, Western Reserve University; Dr. Charles A. Doan, dean of the Ohio State University College of Medicine; and Dr. George L. Sackett, Cleveland, who is a member of the Ohio Public Health Advisory Council.

Other appointees include Dr. Thomas Mancuso, chief of the Division of Industrial Hygiene of the Ohio Department of Health, appointed to the study group on control and regulations; and Dr. William G. Myers, director of the Division of Medical Physics and Radioisotopes at Ohio State University, appointed to the study group on research.

Following are the five objectives of the Governor's Advisory Council:

1. Systematic examination of the various fields of Ohio society affected by the introduction of atomic energy and its by-products.

2. Distribution, both through the established state departments and semi-public organizations, of needed information on the peacetime uses of this new power.

3. Suggesting possible activities to encourage further expansion of industrial uses of atomic energy in Ohio.

4. Assistance to industrial organizations, research centers (both public and private) and educational and state departments in directing attention to Ohio as a recognized center of atomic uses and research.

5. Advising the Governor and other state officials as to needed steps to provide the greatest opportunity for atomic development, at the same time providing for maximum safety protection both of the individual and the community.

Despite increased postponement of widowhood to the older ages as a result of the declining mortality prior to midlife, last year 115,000 wives were widowed in the United States through the death of a husband less than 55 years of age. —Metropolitan Life.

What Will Congress Do? . . .

Facts and Predictions On Medical-Health Proposals in Hoppers of 85th Congress Presented in Special Report of AMA Washington Office

THE 85th, Democratic-controlled U. S. Congress is under way and bills already are piling up in the hoppers. More than 1,500 measures were introduced on the first day in the House alone.

What is the outlook regarding medical and health legislation?

This question is covered in a special report issued by the Washington Office of the American Medical Association several days after Congress convened.

The report points out that "two factors of overriding importance should be kept in mind," namely:

"**First**, beyond much question the new Congress, like the last one, will be anxious to vote large sums of money for existing programs, particularly research, and to set up new programs in the health and medical fields. This Congress will not be afraid of spending money or of starting health-medical programs that might be considered experimental.

"**Second**, while the administration may be able to exercise some degree of restraint on Senate and House, the greatest moderating force will be the demands, probably bi-partisan, for a step-up in military and foreign aid spending. There can't be unlimited military and foreign aid dollars, and at the same time unlimited health-medical dollars.

"As usual, a majority of the health bills won't even be considered seriously by the committees. Some will be the subject of hearings, but not reported out of committee. A few will move on to enactment. However, keep this in mind: All bills not enacted or actually defeated will hold over through 1958 and can be picked up at exactly the point they had reached at adjournment of the 1957 session."

Following are excerpts from the special report, enumerating and explaining some of the measures which have been introduced, or will be presented, during the session:

CONSTRUCTION GRANTS FOR MEDICAL SCHOOLS

The administration again is asking Congress to authorize construction grants for medical, dental, public health and osteopathic schools. The money would be used to help pay for facilities for more students rather than for salaries of teachers or for maintenance costs. The staff of the House Interstate and Foreign Commerce Committee has been gathering data on medical school problems since the last Congress adjourned, and may take up the subject early in this session.

The administration sought last year to get a combined bill for grants for building laboratory facilities as well as classrooms, but Congress decided to grant only the former and give the latter more study. The original plan was for an authorization of $250 million over a 5-year period for both laboratories and classrooms. Congress authorized $90 million over a 3-year period for laboratories.

FEDERAL WORKERS HEALTH INSURANCE

Some of the more optimistic officials concerned with getting a program of contributory, voluntary health insurance underway for federal civilian workers feel it can be accomplished this year. Certainly no single proposal in the health field in recent years has been worked over for so long a period.

The goal now is to produce a "package" bill with both basic and catastrophic coverage—one that will meet the approval of the non-profit plans, the commercial carriers and the federal employees unions. Two previous proposals—one for basic and the other for catastrophic coverage —have failed to pass because of objections of one or more groups to some aspect of the plans.

VOLUNTARY HEALTH INSURANCE

Both the administration and the Democrats are working on ways to bring about more rapid expansion of health insurance. The administration's reinsurance plan, twice rejected by Congress, remains in the background. Coming to the fore this year is a substitute plan which would permit smaller insurance companies (the larger ones say they don't need it) to pool their resources without violating anti-trust laws. It is felt this would stimulate coverage for major medical expenses, for farmers, for the aged and for low-income families. The plan was introduced last session but too late for hearings.

A liberal Democratic favorite in this field is the plan for federal grants to states to help them establish new health plans or assist existing plans. Under it, persons would purchase health insurance with premiums scaled according to their income. The indigent would receive the insurance without cost. This proposal is certain to be pushed in the 85th Congress.

Any legislation that results could combine some of the features of the three different approaches under study.

TAX DEFERMENT ON RETIREMENT PLANS

Interest has been revived in the Jenkins-Keogh plan for permitting the self-employed to defer payment of taxes on money paid into retirement plans. The American Bar Association is pushing for enactment of a bill this session, and has re-

ported that more than half of the members of the House favor the principle of tax deferment for self-employed. Supporters of the proposal (which include the American Medical Association) point out that enactment of the plan would place professional groups on a par with employed persons. Industry now is permitted to deduct money paid into annuities.

The cost of this proposal will be one of the points on which it will be vigorously attacked. Both the administration and the Democrats are opposed to any legislation that would reduce tax income and unbalance the budget.

REGULAR DRAFT AMENDMENT FOR DOCTORS

The 6-year-old doctor draft act expires this July 1, and barring any new emergency, the Defense Department says it will not ask Congress to extend it. In its stead, the Defense Department plans to ask for an amendment to the regular draft to provide for the selective callup of doctors under age 35 who have been deferred to complete their education. These groups have an obligation under the regular draft for two years of service unless exempted for specific reasons. Meanwhile, to encourage young doctors to take their military training after leaving medical school and possibly elect to make military medicine a life-time career, the services are sponsoring intern and residency training programs. Under this special deferment plan, doctors promise active service at a later date.

SOCIAL SECURITY AMENDMENTS

If this Congress runs true to form, there will be an abundance of bills designed to further liberalize the much-amended Social Security Act. There will be demands for lowering age for disability cash payments (set at age 50 by the last Congress), for a program of payments for temporary disability, for hospitalization of those over 65 who are eligible for current old age benefits, and, to help finance these and other plans, a higher ceiling on earnings subject to social security tax.

Disability Payments—Payments to workers covered under social security who have been found totally and permanently disabled at age 50 or older will start next July 1. Before then bills can be expected that would do away with the age limit entirely, and also extend cash payments to dependents of the totally disabled.

Temporary Disability—As far back as 1948, bills were sponsored for payment of federal social security benefits to covered workers suffering from temporary disability, regardless of age. Four states now have temporary disability payment programs (California, New York, Rhode Island, and New Jersey) and, legislation for federal action is certain to be pushed by some groups.

Hospitalization for the Aged—A perennial favorite of some legislators is the plan for giving social security beneficiaries aged 65 or older free hospitalization in civilian facilities. With new emphasis being placed on aiding the aging population, efforts will be made again to enact this hospitalization proposal.

FEDERAL AID FOR THE AGING

With Secretary Folsom himself heading the new Federal Council on Aging, the Eisenhower administration is planning new efforts to help solve some of the social problems of the aged. While details are not near filled in, it is contemplated a number of government departments will work together on this effort. In Congress, Senators Hill and Kennedy are expected to press for their bill which authorizes federal grants to states. The money would be used for studies and demonstrations on how best to meet the problems of the aged.

Like the House Interstate Committee staff which in the last few months has done considerable spadework in medical education, the Senate Labor and Public Welfare Committee headed by Senator Hill has had its staff make an extensive study of the problems of older people. Just before the last session ended, the Senate adopted a resolution calling for such a study. The committee's first release in this area was a compilation of reports on activities of individual states and the federal government on behalf of the aged. Subsequent reports will include health problems of the aged.

MEDICAL RESEARCH

Money for medical research again will loom as a major health item in the budget, and Congress, if it follows the pattern of recent years, will vote even bigger sums than asked by the administration. Some members of Congress, including key members of the House Appropriations Committee, have questioned whether there are enough qualified medical researchers to make good use of the huge appropriations.

Poliomyelitis Vaccine Grants Act—Congress will have to decide before next July 1 whether, in the light of a great backlog of supplies, to extend the law which gives the states money to help them in free vaccine programs against poliomyelitis. The administration has been urging the public to take inoculations now, in view of the oversupply of vaccine.

Bricker Amendment—Senator Bricker (R., Ohio) again is sponsoring a version of his proposed amendment to the Constitution to prevent enactment of domestic law through treaty or executive agreements.

Local Public Health Units—More activity may be expected on federal aid to local public health units, a proposal that failed of passage several years ago when Congress could not agree on the definition of what is public health.

Nursing School Aid—Similarly, bills on federal grants for building nursing schools are expected, as well as on funds for maintenance and scholarships.

New Facts on Medicare Program . . .

Mutual of Omaha Is Named To Administer Medical Details in This State For Federal Government; Doctors Submit Forms Through That Agency

AS PREDICTED in the January issue of *The Journal*, administrative and fiscal details in Ohio for the Military Dependents Medical Care Program (Medicare) are now being handled by the Mutual Benefit Health and Accident Association of Omaha, Nebraska (Mutual of Omaha), under a contract negotiated with the Washington Medicare Office, which became effective January 14.

The Medicare Program became effective nationwide on December 7, and eligible dependents of military personnel treated by physicians on and after that date are covered. Refer to December and January issues of *The Journal* for details.

Mutual of Omaha will receive and process all medical forms and will disburse fees to Ohio physicians caring for patients under the Medicare Program. Hospital details in Ohio are being administered by the various Blue Cross plans in the state.

WHERE TO SEND FORMS

Any Ohio physician who has taken care of a patient under the Medicare Program (on or after December 7) and who has not as yet filed a Form 1863 to secure payment for services, should send the completed Form 1863 to: Dependents Medical Care Department, Mutual of Omaha, Post Office Box 1298, Omaha, Nebraska. The form will be processed there and payment made from that office. Any inquiries which physicians have in regard to the program should be directed to the same address.

The Office of the Surgeon, Second Army at Fort Meade, Maryland, has discontinued its temporary job as administrative agent for the Medicare Program in Ohio. That office has sent to Mutual of Omaha all forms received there and not previously processed. Physicians should discontinue sending forms to that office, but should not resubmit bills previously sent there. All bills not previously submitted should be sent to Mutual of Omaha regardless of when the service was rendered (on or after December 7).

A schedule of Allowances for Ohio Physicians, has been drafted by the Washington Medicare Office, after conferences with officials of the Ohio State Medical Association. Every member of the Ohio State Medical Association should have received by this time from Mutual of Omaha, a copy (gray booklet) of the Schedule of Allowances. Also, it contains pertinent information and rules regarding administrative procedure. Any Ohio physician who has not received a copy of the booklet should write directly to Mutual of Omaha for a copy.

Some Essential Points in Filing Form 1863

Physicians' claims under the Medicare Program, filed on Form 1863, will be processed by the thousands. It is essential, therefore, that certain definite information be given to expedite processing. Here are some points to remember:

Two copies of Form 1863 must be submitted—an original and one duplicate. It would be a good idea for the physician to keep an additional copy for his own file, although this is not required.

Identification card number and expiration date must appear on the form. Items 1 through 14 may be filled out from the identification card and information furnished by the patient.

The "certification of dependent" must be signed by the patient, or in the case of a child by the parent or acting guardian. This probably means, the original and duplicate both should be signed.

In the case of a dependent receiving obstetric and maternal care, both the "certification of dependent" and the "additional certification" must be signed.

In the case of a child, the "acting guardian" may be any person to whom the patient's dependency to the member of the uniformed services is well known and who will so certify. When a parent or guardian signs for a child, the relationship of the person signing to the patient should be indicated in the space for the "typed or printed name."

The name and complete mailing address of the physician should be typed under item 16, or printed clearly so that the agency will have no difficulty mailing check.

SUPPLY OF FORMS

To try to solve the problem of keeping physicians supplied with Form 1863, Mutual of Omaha will send batches of the form to Secretaries of County Medical Societies. This procedure was suggested by the Ohio State Medical Association as the most feasible method of making forms readily available. Secretaries have been requested to make the forms available to physicians in their respective counties.

The Washington Medicare Office has announced that physicians near state lines will be compen-

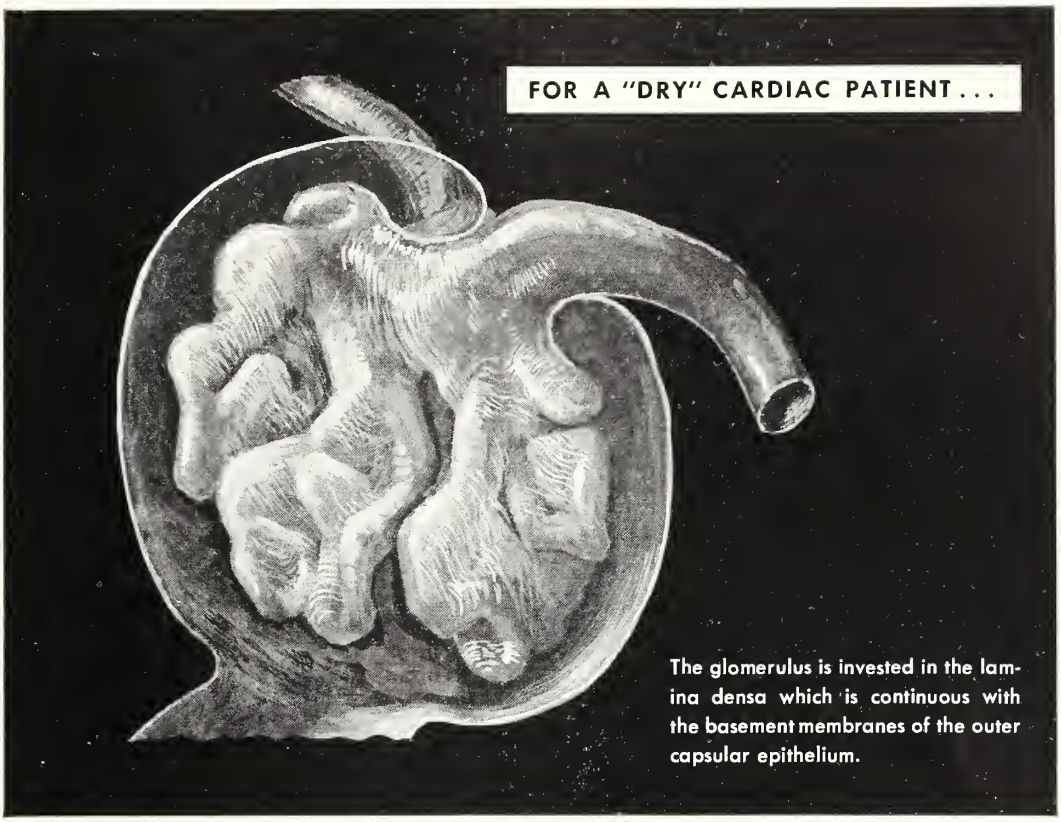


Illustration by Hans Elias

Rolicton® Diuresis Maintains Continuous Edema Control

The efficacy of Rolicton (brand of amisometradine) in maintaining diuresis in the edematous patient has been established on an average dosage of one tablet b.i.d. Larger doses may be given as initial therapy and as maintenance therapy in edema difficult to control. Many patients will respond to one tablet daily.

"The margin of safety and the diuretic index is certainly an improvement over the use of oral mercurial diuretics."[1]

Avoiding "Peaks and Valleys"

A highly desirable effect, and one which has been made possible with Rolicton, is the maintenance of continuous diuretic effectiveness day after day over an extended period, to avoid the up-and-down weight pattern typical of other edema-control methods.

"There was an obvious stabilization of weight in practically all of the patients under observation, and previous wide fluctuations in poundage disappeared."[2]

Mercury-Sparing

Typical of the Rolicton diuresis pattern is the ability of the drug to reduce and, in a large percentage of patients, to eliminate the need for mercurials parenterally.

". . . the drug represents a most useful addition to our armamentarium in the treatment of edema, not only because it can be given orally . . . but more so because it permits [us] to replace or to spare the . . . mercurials."[3]

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

1. Asher, G.: Personal communication, June 23, 1956.
2. Settel, E.: A Clinical Evaluation of a New Oral Diuretic, Rolicton, Postgrad. Med., Feb. 1957, in press.
3. Goldner, M. G.: Personal communication, June 29, 1956.

SEARLE

sated under the program in line with the Schedule of Allowances applicable to the state in which services were rendered. Form 1863 should be sent to the Medicare Program fiscal administrator having jurisdiction in the state where the services were rendered.

Ohio physicians are invited to refer to Medicare Program articles in the December and January issues of *The Journal;* also the *OSMAgrams* for December 7 and January 15. These articles explain details of the program—how it operates, who is eligible, who isn't eligible, what is covered, and so forth. The new Medical Manual will explain details as soon as it is available.

Although the OSMA has signed no contract with the Medicare Office in Washington, it has been in conference with Medicare officials and has offered to cooperate in the administration of the program in Ohio and in keeping physicians informed on the program. For this purpose The Council authorized appointment of a new committee to be known as the Committee on Government Medical Services and to act in an advisory capacity on the Medicare Program. The following committee has been appointed: Dr. Robert S. Martin, Zanesville, chairman; Dr. Charles L. Hudson, Cleveland; Dr. Frank H. Mayfield, Cincinnati; Dr. Edwin H. Artman, Chillicothe; Dr. Robert E. Hopkins, Coshocton; and Dr. George W. Petznick, Shaker Heights.

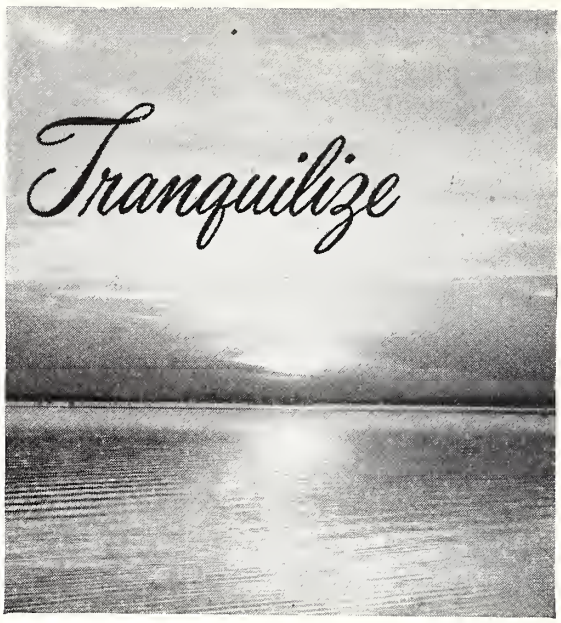
IDENTIFICATION AND SIGNATURES

Physicians are cautioned in filing claims on Form 1863 to be sure to include the identification card number and expiration date thereof in the space provided. Claims cannot be processed without this information.

The data required under items 1 through 14 are to be obtained from the patient and the "certification of dependent" under Section III is to be signed by the patient; or in the case of a child by the parent or guardian. In the case of a dependent who is rendered obstetrical and maternal care, the patient is required also to sign the "additional certification required of dependent receiving obstetrical and maternity care." Failure to obtain this additional signature will delay processing.

Lithuanian-American Doctors Organize Ohio Society

Some 60 doctors of Lithuanian descent met recently in Cleveland and organized the Lithuanian-American Medical Association of Ohio. They adopted by-laws of the society and elected the following officers: Dr. Daniel Degesys, 6712 Superior Ave., Cleveland 3, president; Dr. Jonas Stankaitis, Cleveland, first vice-president; Dr. Jurgis Balciunas, Strasburg, second vice-president; Dr. Vladas Ramanauskas, Cleveland, treasurer; and Dr. Dominika Kesiunas, 928 East 79th St., Cleveland 3, secretary.



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Ohio Legislature . . .

Session Started on January 7; Veteran Leaders Selected; Those Appointed to Health Committee and Other Important Committees

THE Ohio General Assembly is rolling, having convened on January 7. The lineup in the Senate is 22 Republicans and 12 Democrats and in the House, 97 Republicans and 42 Democrats.

The Senate organized by electing the veteran Senator C. Stanley Mechem, Athens County, president pro tem (Republican floor leader) and Senator Joseph Bartunek, Cuyahoga County, Democratic floor leader. In the House, Rep. Roger Cloud, Logan County, was re-elected Speaker; Rep. Kline Roberts, Franklin County, re-elected Republican floor leader; and Rep. James J. McGettrick, Cuyahoga County, Democratic floor leader.

COMMITTEE APPOINTMENTS

Following are appointments made to some of the Senate and House committees—those in which the medical profession will be especially interested because bills in which it will be interested will be referred to these committees for hearings:

Senate Education and Health Committee: Charles A. Mosher, Lorain-co, Chairman, (R); Oakley C. Collins, Lawrence-co, vice-chairman, (R); Delbert L. Latta, Hancock-co (R); Raymond E. Hildebrand, Lucas-co (R); Gordan Renner, Hamilton-co (R); Ross Pepple, Allen-co (R); William Beckett, Butler-co (R); C. Lee Mantle, Lake-co (R); Charles J. Carney, Mahoning-co (D); Frank W. King, Lucas-co (D); Julius J. Petrash, Cuyahoga-co (D).

Senate Judiciary Committee: William Tyrrell, Preble-co, Chairman, (R); Delbert Latta, Hancock-co, vice-chairman, (R); Fred L. Hoffman, Hamilton-co (R); David E. Morgan, Franklin-co (R); J. E. Simpson, Hardin-co (R); Andrew C. Putka, Cuyahoga-co (D); Frank D. Celebrezze, Jr., Cuyahoga-co (D).

Senate Rules Committee: C. Stanley Mechem, Athens-co, Chairman, (R); Tom V. Moorehead, Muskingum-co (R); William H. Deddens, Hamilton-co (R); David McK. Ferguson, Guernsey-co (R); Theodore M. Gray, Miami-co (R); Joseph Bartunek, Cuyahoga-co (R); Arthur Blake, Belmont-co (D).

House Health Committee: Harold Oyster, Washington-co, Chairman (R); John Ashbrook, Licking-co (R); Harry Corkwell, Putnam-co (R); John Hayden, Clermont-co (R); Charles F. Kurfess, Wood-co (R); David M. Phillips, Ross-co (R); John C. Pollock, Lake-co (R); Archer E. Reilly, Jr., Franklin-co (R); Mrs. Clara E. Weisenborn, Montgomery-co (R); Mrs. Anne M. Donnelly, Cuyahoga-co (D); Norman A. Fuerst, Cuyahoga-co (D); Vernon G. Hisrich, Tuscarawas-co (D); George Hook, Brown-co (D).

House Rules Committee: Roger Cloud, Speaker, Logan-co, Chairman, (R); Robert F. Groneman, Hamilton-co (R); Robert L. Johnson, Medina-co (R); Joseph E. Lady, Hardin-co (R); Virgil Perrill, Fayette-co (R); Kline Roberts, Franklin-co (R); James Sexton, Butler-co (R); Bishop Kilpatrick, Trumbull-co (D); James J. McGettrick, Cuyahoga-co (D); Ed Wallace, Pickaway-co (D).

House Public Welfare: Harry Corkwell, Putnam-co, Chairman, (R); Max H. Dennis, Clinton-co (R); Mrs. Golda M. Edmonston, Franklin-co (R); Charles H. Jones, Butler-co (R); Harry V. Jump, Huron-co (R); Ray Miller, Paulding-co (R); Joseph Pierson, Preble-co (R); Dwight Raudenbush, Mercer-co (R); James Sexton, Butler-co (R); Mrs. Ethel Swanbeck, Erie-co (R); Wayne Ward, Athens-co (R); Howard L. Williams, Trumbull-co (R); Mrs. Loretta Woods, Scioto-co (R); Hugh A. Corrigan, Cuyahoga-co (D); Mrs. Anne M. Donnelly, Cuyahoga-co (D); Norman A. Fuerst, Cuyahoga-co (D); James A. Lantz, Fairfield-co (D); Frank R. Pokorny, Cuyahoga-co (D); Francis F. Reno, Lucas-co (D).

SALARY INCREASE BILL PASSED

Of major importance was the passage by the General Assembly during its first week, of an emergency bill increasing the salaries of 12 state department heads and 22 other state officials, primarily members of certain administrative commissions. This action was taken at the request of the new Governor, C. William O'Neill, to enable him to interest more able, more competent persons in taking appointments to cabinet and state administrative jobs.

Among the salaries increased was that of the Director of the Department of Mental Hygiene and Correction—to $25,000. Also, the term was increased to six years. The salary of the Director of the Department of Health was raised to $18,000 but, unfortunately, the salary of the incumbent, Dr. Ralph Dwork, must remain at $12,000 because of the constitutional prohibition against change in the salary of a state official during his current term, which will not expire until November 7, 1959.

BULLETINS TO COUNTIES

As in the past, the Legislative Committee and Columbus Office Staff of the Ohio State Medical

Association will cover the sessions of the General Assembly on a day-by-day basis. Regular bulletins will be sent weekly to the officers and legislative chairmen of County Medical Societies. They will be expected to keep in close touch with their respective legislators in order to keep them informed of the views of the medical profession on pending bills. Witnesses from the Association will appear before committees to express the official views of the Association on bills and to supply legislators with information on medical and health questions.

Phi Delta Epsilon at OSU To Have Dr. Furstenberg as Guest

Phi Delta Epsilon will have as guest speaker on February 26 Dr. Albert C. Furstenberg, dean of the University of Michigan Medical School and chief of the Department of Otolaryngology. This constitutes the annual Aaron Brown Lectureship and Dr. Furstenberg has chosen as his topic, "A Look to the Future."

During the day of February 26, Dr. Furstenberg will conduct rounds at University Hospital. The Phi Delta Epsilon banquet will be held at the Ohio Union on the OSU Campus at 6 p. m. on the same date, followed by the lecture at 8:30. All physicians interested are invited to hear the lecture.

New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since December 1, 1956. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ALLEN COUNTY

James C. Belt, Delphos
Robert J. Kobs, Lima
Walter W. Wolery, Delphos

CUYAHOGA COUNTY

John M. Clough, Cleveland
Charles J. Hearn, Cleveland
Edwin R. King, Cleveland
Sidney Krohn, Cleveland
Ignatz Vidu, Cleveland

FRANKLIN COUNTY

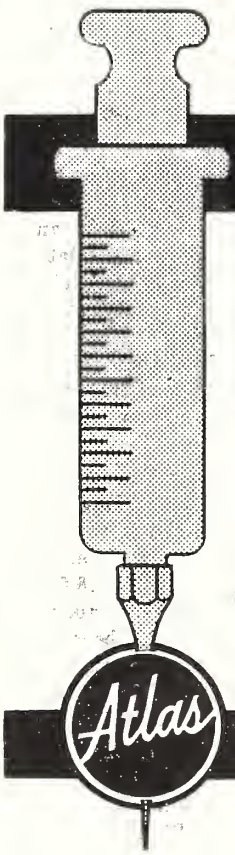
William H. Brunie, Worthington
Robert J. Duran, Columbus
Matthew Wm. Elson, Columbus
Walter M. Haynes, Jr., Columbus
Benjamin Kaplan, Columbus
Azad Katchian, Cincinnati
Heinrich J. Leuchter, Columbus
Otto J. Lowy, Columbus
Bernard H. Marks, Columbus
William G. Rice, Columbus
Henry A. Rowe, Dublin

MONTGOMERY COUNTY

James M. Cunningham, Dayton
Albert B. Huffer, Dayton
Herbert U. Seabrook, Dayton
G. Douglas Talbott, Dayton
William R. Whitaker, Dayton

SUMMIT COUNTY

Charles W. Loughry, Akron
Bruce F. Rothmann, Akron
George D. Solomon, Jr., Cuyahoga Falls
Anthony D. Vamvas, Jr., Akron



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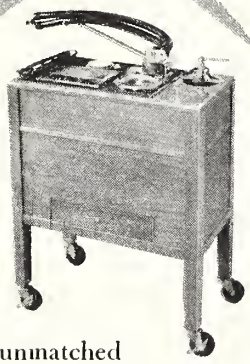
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There are many short periods of time
which, if measured correctly, are considered valuable
diagnostic durations — such as the P-R interval in ECG interpretation,
and the minutes during which a patient consumes oxygen in
a BMR test. If the readings related to these measurements are to be used
with complete confidence, it is wise to consider another important
measure of time — and that is the *background* of the
instruments which
produced them.

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The TIME TESTED *diagnostic team*



Sanborn
Metabulator

No one understands
better than a physician
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become suitably proficient
in a chosen work. The unmatched
background of knowledge and experience making possible
such fine instruments as the Viso-Cardiette and Metabulator
did not come about overnight, and is the result of almost
40 years of successful medical instrument development. Such
a background assures you that it is safer to select Sanborn.

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Cincinnati Academy Centennial . . .

All Ohio Physicians, Their Families and Patients Are Invited for Exposition Week of February 27-March 5; Special Guest Speakers

THE Academy of Medicine of Cincinnati cordially invites all physicians, their families, and their patients to its 100th Birthday Party, February 27 through March 5, 1957. In order to officially observe the occasion, a Health Museum and Exposition will be established in Cincinnati's spacious and historic Music Hall. One hundred and seventy-five health and scientific exhibits, representing medicine, hospitals, research centers, public health, nursing, pharmacy, and industry, will be displayed in the north and south halls. Notable among these exhibits and occupying some 4,000 square feet of space will be an atomic energy exhibit from the American Museum of Atomic Energy entitled "Atoms for Peace."

In the main foyer of the hall "Juno," a full-sized, activated manikin, graciously loaned for the occasion by the Dominican Republic, will be on display. Juno is operated electrically, and with concurrent recorded narration, will demonstrate blood vessels, bones and organ structures of the body.

The ribbon-cutting ceremony for the Centennial Exposition will be conducted by the Honorable William O'Neil, Governor of the State of Ohio, at 9:00 A. M., Wednesday, February 27.

Dr. Paul D. White and Dr. Walter Alvarez, noted medical scientists and authors, have accepted invitations to be among the distinguished guest speakers.

SIR EDWARD APPLETON

Sir Edward Victor Appleton, a Nobel Award winner, one of the foremost scientists of the present generation, will be the featured speaker at the Convocation of the Academy in Music Hall at 8:30 p. m., March 5. Sir Edward holds many honors and decorations from his own country as well as other nations, including the Grand Cross of the British Empire, Knight Commander of the Bath. The 65 year old scientist won the Nobel Award in physics for the year 1947. Besides degrees from Cambridge, Sir Edward holds doctor of science degrees from Oxford, Leeds, Brussels and Sidney Universities. The American Institute of Radio Engineers awarded him its Liebmann Memorial Prize in 1929 and he also was presented the United States Medal of Honor for his achievements in physics. Since 1949 he has been Principal and Vice Chancellor of the University of Edinburgh, Scotland.

Professor Reginald McGrane, chairman of the Department of History, University of Cincinnati, has prepared a one hundred-year history of the Academy of Medicine, entitled "The Doctor's Forum." Copies of this volume will be available at the Centennial Exposition. The *Cincinnati Journal of Medicine* is preparing a special Centennial Edition for the occasion.

CIVIL DEFENSE HOSPITAL

The Centennial Exposition will include an exhibit of the Ohio Valley Civil Defense Authority illustrating a typical 200-bed emergency hospital.

The Civil Defense exhibit to occupy 1600 square feet in the South Hall of Music Hall is planned as one of the civic interest features of the week-long Health Show.

The exhibit—which along with the entire Centennial Exposition's 175 booth unit attractions will be free to the public—has been obtained from the national Civil Defense authority for showing in Cincinnati.

The exposition will be open daily from 10 a. m. to 10 p. m. Admission is free.

In an effort to supplement existing hospital



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JOHN H. NICHOLS, M. D., Medical Director G. PAULINE WELLS, R. N., Admin. Director HERBERT A. SIHLER, JR., Sec'y.
MEMBER: American Hospital Association — Central Neuropsychiatric Hospital Association
National Association of Private Psychiatric Hospitals
ACCREDITED: by the Joint Commission on Accreditation of Hospitals

facilities in target cities throughout the country, the Federal Civil Defense Administration has developed a 200-bed emergency hospital unit that can be set up in a building or used as a field unit.

Costing $22,500.00 the hospital features 10 wards of 20 beds each; a laboratory; three complete operating rooms; x-ray; sterilizing rooms; a pharmacy and central supply section complete with supplies sufficient for a 36 to 48 hour operation.

Stored in warehouses throughout the country and away from critical targets, these hospitals with supplies can be loaded in two large vans and rushed to disaster areas and be in operation five hours after arrival.

Set up in outlying areas, the hospitals would provide working facilities for doctors and nurses evacuated from the regular hospitals in the Cincinnati target area.

In a war-caused emergency it is estimated that the Cincinnati-Hamilton County area would need at least 50 Emergency Hospital Units.

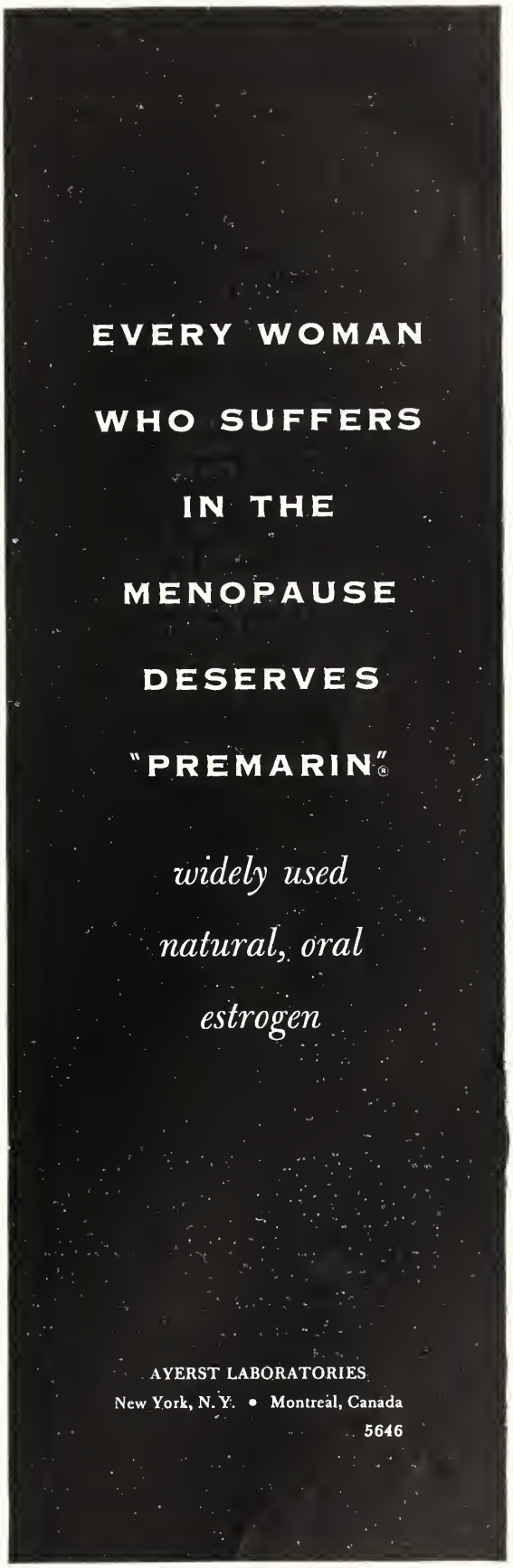
AUXILIARY MEMBERS TO GUIDE TOURS

Members of the Woman's Auxiliary to the Academy are busy helping to make plans for the special event. The Exposition will serve, by exhibits and lectures, to demonstrate to the lay public the many private, public and voluntary organizations which are united to help the physician in the care and comfort of the patient. In addition to the health information to be garnered, it is hoped that the exposition will inspire more young people to choose careers in the health field.

With this latter thought in mind, and in cooperation with the school systems of Hamilton County and surrounding territory in Ohio, Indiana, and Kentucky, thousands of children in Junior and Senior High Schools will be taken through Music Hall to view the exhibits. Responsibility for these tours has been given to the Auxiliary. If the number of students is too large for this group to handle, assistance will be sought from allied professional auxiliaries. The tours will necessarily vary but each child will be shown three major exhibits and several other booths during the time allotted, with the suggestion that he return with his parents to view more of the many other exhibits.

In addition to the school tours, Auxiliary members will be assisting when and where needed in individual booths such as the Academy Publications, Future Nurse Clubs and Specialty Groups.

All Auxiliary members throughout Ohio have a special invitation from the Cincinnati Auxiliary to attend and to bring their families and friends.



Facts and Policies About Annual Dues . . .

Amount of Dues; Date Due; Payable to Whom? Those Exempt From Payment; Data on AMA Dues and Exemptions; Getting Journals

HERE are some important facts and reminders regarding 1957 membership dues. It is vital for each physician to keep his membership in the State Association, his county Medical Society, and the AMA up to date. Those who have not paid 1957 dues should get in touch with their County Society secretary-treasurer immediately.

Amount of Dues: State Association, $25.00 or $7.50 in the case of interns and residents; AMA, $25.00; County Society, amount varies from county to county—See your local secretary-treasurer.

Membership and Dues for Residents and Interns: A physician serving a hospital internship or residency within a period of five years following graduation from the medical school (excluding time in military service), who becomes a member of a county medical society and meets the membership eligibility requirements of the OSMA By-Laws, **does not** have to pay full state dues for 1957. By official action of The Council September 15-16, 1956, state dues for such members were set for 1957 at $7.50. Such members will not receive *The Journal* automatically but may subscribe to *The Journal* at one-half the regular rate—namely for $2.50.

So far as AMA membership is concerned, the AMA By-Laws provide that it may excuse from the payment of AMA dues, interns and residents during the first five years following graduation from medical school (excepting military service) provided their local and state dues are fully or partially waived. Therefore, intern and resident members in Ohio who are assessed the partial dues ($7.50) will be entitled to AMA membership without payment of AMA dues. However, in order to receive the *AMA Journal* or some other AMA publication, they will have to purchase a regular subscription from the AMA.

Date Dues are Due: On or before January 1, 1957. Membership is on a calendar year basis.

Dues Payable to Whom?: Secretary-treasurer of County Medical Society. When paying dues to him, send check for total amount of local, State and AMA dues. Maintaining membership in the AMA is optional, but the large majority of Ohio physicians belong to the AMA. Don't send dues direct to Columbus Office—pay them to local secretary-treasurer.

Who is Exempt From State Dues? There are only two classes of members of the OSMA who are exempt from the payment of state dues, namely:

(a) **Military Members:** Members of the OSMA on extended active duty in the military service or U. S. Public Health Service but who are not making military medicine or public health work a career, are entitled to exemption from OSMA membership dues while they are in the service. Dues paid by a member before entering the service will not be refunded, but dues will be waived if he enters the service prior to paying dues. Certification from local secretaries will be necessary in all such cases.

(b) **Aged or Disabled Members:** A member who retires, or has been retired, from active practice because of age or disability and who was in good standing at the time of retirement is exempt from the payment of State dues, **providing he requests such exemption and such request is approved in writing by the secretary-treasurer of his county medical society.**

Remember: The determining factor is not how old the physician is but whether he has retired from active practice.

Who Is Exempt From AMA Dues?: The following physicians, who are members of the OSMA either through payment of OSMA dues or by exemption of OSMA dues, can carry membership in the AMA without paying AMA dues:

(a) **Military Members:** OSMA members in temporary military service prior to January 1, 1957, are entitled to AMA membership **without payment of dues.** Members entering military service prior to July 1, 1957, will owe AMA membership dues of $12.50—one-half year; those entering military service after July 1, 1957, will owe dues for the entire year—$25.00. Military members for whom AMA dues are waived and who desire to receive *The AMA Journal* while in the service may do so by buying, directly from the AMA, an annual subscription in the amount of $15.00. The *OSMA Journal* is sent to such members without charge.

(b) **Aged and Disabled Members:** OSMA members who are exempt from payment of OSMA dues because of retirement from active practice due to age or disability are entitled to AMA membership without payment of AMA dues. The names of such members will be certified automatically to the AMA annually by the Columbus Office after their names are entered on the OSMA roster as dues-exempt members for the current year.

(c) **Members 70 years of age:** Members of the OSMA, after attaining the age of 70 years, will be eligible for membership in the AMA

without paying AMA dues, **starting on January 1 following such member's 70th birthday, providing such member requests such exemption.** Such members should file their request for AMA exemption with the Columbus Office after they have received their OSMA membership card for 1957, or any subsequent current year. The Columbus Office will certify their names to the AMA. This AMA exemption will be automatic year by year, providing the physician's name is carried on the membership roster of the OSMA, either as a dues-paying member or as a retired member. To get the *AMA Journal* these 70-year old members must purchase a subscription.

(d) Members of the OSMA who are serving an internship or residency during the first five years following graduation from medical school (excluding time in military service). This is because their dues are partially waived by the OSMA (they pay only $7.50 to OSMA). Those in postgraduate training after the five-year period are not excluded from paying AMA dues.

Those not exempt from OSMA dues: The following are not exempt from the payment of OSMA dues, either $25.00 or $7.50:

(a) **Members in practice or in internship or residency training.** As mentioned previously, those in internship or residency during the first five years following graduation from medical school (excluding time in military service) are assessed dues of $7.50—not $25.00 the dues of other classes of paying members.

(b) **Regular commissioned medical officers of the Army, Navy, Air Force, or U. S. Public Health Service, and permanent medical officers of the Veterans Service and the Indian Service are NOT exempt from OSMA dues.** If they desire to be members of the OSMA, they must qualify the same as civilian physicians and pay current dues. However, physicians of these classes are eligible to apply for **Service Membership in the AMA**, and if accepted into Service Membership, will not be required to pay AMA dues.

Send Change of Address Promptly: Occasionally a new member wonders why he does not receive the OSMA and AMA journals at once. The answer is simple. It takes the OSMA Columbus Office about four weeks to get a new stencil made and the mailing list adjusted to take care of mailings to new members. It takes the AMA longer because of its very large mailing list. Also, some months extra copies of the journals are quickly exhausted. Moreover, the Post Office Department frequently causes the delay in delivery. The Columbus Office makes a real effort to send out OSMA journals to new members by special handling but that can't always be expedited. If a new member fails to get the magazine on two consecutive months, something is wrong and he should notify the Columbus Office. All members can help the Columbus Office in keeping the mailing list up to date by sending in changes of address promptly.

Journals: State Association members, who pay full dues or are exempt from payment of any dues, receive *The Ohio State Medical Journal* as a part of their membership privileges—no extra charge for *OSMA Journal*. Those who pay dues to AMA receive the *Journal of the AMA* as a part of their membership privileges—no extra charge for *AMA Journal*.

A dues-paying AMA member may secure in lieu of the *AMA Journal*, any other official publication of the AMA **on special request by him direct to the AMA** at 535 N. Dearborn Street, Chicago. These publications are: *Archives of Internal Medicine, American Journal of Diseases of Children, Archives of Dermatology and Syphilology, Archives of Neurology and Psychiatry, Archives of Pathology, Archives of Surgery, Archives of Otolaryngology, Archives of Ophthalmology,* and *Archives of Industrial Hygiene and Occupational Medicine.*

Those exempted from payment of AMA dues must place a special subscription for the *AMA Journal* direct to the AMA or any one of the other publications if they desire to receive such publication.

Status of Medical and Dental Students Not Necessarily Changed by Recent Alert Order

Medical and dental students who are also Reservists have recently received a Department of the Army notice titled "Period of Alert for Active Duty for Members of the Army Reserve." According to Col. James H. Kidder, special assistant for Reserve Forces to the Army Surgeon General, recipients of the notices should not be alarmed.

Members of the Ready Reserve are subject to involuntary order to active duty either in time of war or proclaimed national emergency. Since the nature of a national emergency, particularly in view of the overall world situation, cannot be predicted, each Ready Reservist should have his personal affairs in order, as he may be ordered to active duty in less time than the intended 30 day alert.

Medical and dental students, who also are Ready Reservists, are being reminded of the law as a routine measure and in no way should the action be construed as directly connected with any single international incident.

The Army intends that medical and dental students who are in the Ready Reserve while enrolled in a graduate course or professional school will continue to be granted delays or renewals consistent with the current situations.

State Medical Board Examinations . . .

List of Questions for December Examinations Are Given; Total of 111 Doctors of Medicine Apply for Licenses To Practice in Ohio

AT ITS DECEMBER 18-20 examinations in Columbus, the State Medical Board examined 111 doctors of medicine who are seeking licenses to practice medicine and surgery in Ohio, Dr. H. M. Platter, secretary of the Board, reported. This number consisted of 20 graduates of U. S. and Canadian medical schools and 91 graduates of foreign schools.

Examinations also were given to 38 graduates of schools of osteopathy who are seeking licenses to practice osteopathic medicine and surgery in the state.

In the limited practice branches, examinations were given to the following number of persons: Chiropody, 3; mechanotherapy, 10; chiropractic, 47; massage, 29; cosmetic therapy, 6.

Results of the examinations were scheduled to be announced following meetings of the Board January 28 and 29.

Following are the questions given in the examinations for doctors of medicine:

ANATOMY

1. What arteries supply the heart with blood, and where do they originate?
2. What is the circulus arteriosus (Circle of Willis)?
3. What blood vessels pass to and from the liver?
4. Describe the portal system.
5. Give the course and relations of the parotid duct.
6. Describe the arachnoid.
7. What cranial nerve has the widest distribution?
8. Name the seven muscles of the orbit.
9. With what bones does the zygomatic articulate?
10. What structures are severed in tracheotomy?

PHYSIOLOGY

1. Describe the mechanisms of gastric secretion.
2. Describe the physiology of the parathyroid gland: include (a) how it differs from other endocrine glands: (b) Its close relationship with what mineral?
3. Describe normal formation and circulation of bile pigment.
4. Discuss water balance of the body as to
   (a) how and where water is held in the body.
   (b) what influences may cause movement of water from one compartment to another.
   (c) What mechanisms operate to maintain a normal water content of the body.
5. Discuss rhythmicity as a physiological property of the heart.
6. Describe the physiology of:
   (a) a neurone.
   (b) simple reflex arc.
   (c) intercalated neurone (knee jerk reflex)
   (d) simple nervous adaptation.
   (e) complex nervous adaptation.
7. Discuss how the temperature of the body is maintained.
   (b) What factors may alter this equilibrium
8. Describe sugar metabolism and its functions.

9 & 10. **True or False?**

   (a) The gall bladder concentrates bile and returns water and salt into the blood stream.
   (b) When the pressure of bile in the extra hepatic ducts reaches 20 cm. of mercury bile passes into the gall bladder for storage.
   (c) Relaxation of the sphincter of Oddi with contraction of the gall bladder forcing bile into the intestine is brought about by the humeral mechanism.
   (d) Relaxation of the sphincter of Oddi with contraction of the gall bladder forcing bile into the intestine is brought about by the nervous mechanism.
   (e) Circulating indirect reacting bilirubin is transmitted by the Kupffer's cells to the liver cells.
   (f) Cold sweat is produced by strenuous muscular exercise in a cold environment.
   (g) Poor clot retraction indicates a low platelet count.
   (h) A deficiency of the parathyroid hormone may cause cataract formation.
   (i) The cortex of the adrenal gland secretes the androgen, testosterone.
   testosterone.
   (j) A major function of the testes is the formation of spermatozoa by the seminiferous tubules.

BACTERIOLOGY

1. List the bacterial causes of ulcerative stomatitis.
2. List the major pathogenic groups of gram negative bacilli.
3. What micro-organisms should be considered as possible causes of caseous necrosis?
4. Describe the life cycle of ascaris lumbricoides.
5. What is Coomb's serum and how is it useful?

DIAGNOSIS

1. Patient had gastric resection four months ago, followed last two weeks by epigastric pain, inability to move bowels sufficiently, some abdominal distension, appetite good, no loss of weight, no secondary anemia. What may be the cause?
2. Patient, sixty years old, having had paroxysmal tachycardia at least four times a year. Gall bladder with stones was removed, no attack of paroxysmal tachycardia for past year. What part may gall bladder disease play in paroxysmal tachycardia?
3. Patient, thirty-two years old, presents at doctor's office with pain in area between costal margin and ileum, more or less severe at all times, with now and then fever and chills, constipation and vomiting. What might the condition be?
4. Married woman, forty years of age, with a general abdominal pain and interludes of constipation and diarrhea, which condition has prevailed for four years. Give diagnosis.
5. Give the diagnosis of multiple sclerosis in an individual twenty-one years of age.
6. Outline diagnosis and treatment of diabetes insipidus with prognosis.
7. What are the EKG findings in auricular flutter?
8. Discuss briefly:
   (a) Babinski reflex.
   (b) Graham Steell murmur.
   (c) Gallop rhythm.
   (d) Horner's syndrome.
   (e) Homan's sign.
9. Give signs and symptoms of pericarditis with serum effusion.
10. Contrast Cushing's disease and adreno-genital syndrome.

CHEMISTRY

1. Discuss the mechanisms by which, in a healthy individual, the content of glucose in the blood is maintained at an approximate level.
2. Discuss the chemical origin and the function of the hormone of the thyroid gland.
3. Discuss electrolyte imbalance as to causes and give normal range Ca - Na - K
4. Discuss the etiology and pathology of lower nephron nephrosis.
5. Give a satisfactory working classification of jaundice. Give a list of laboratory findings in biliary obstruction.

MATERIA MEDICA AND THERAPEUTICS

1. Name five means for the administration of fluids when ordinary oral administration is not feasible.
2. List advantages and disadvantages of spinal anesthesia.
3. What are some of the general uses of radio-active isotopes?
4. What is the effect of extracts of the adrenal cortex upon the inflammatory reaction to infections and healing of wounds?
5. (a) Give the action of atropine sulphate.
   (b) Symptoms of over dosage.
6. (a) Give two drugs used in treatment of tuberculosis.
   (b) Mode of action.
7. Outline treatment of exposure to atomic bomb explosions.
8. Give the signs and symptoms of digitalis intoxication.

(Continued on Page 222)

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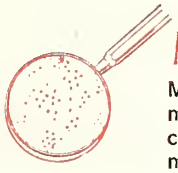
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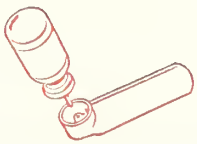


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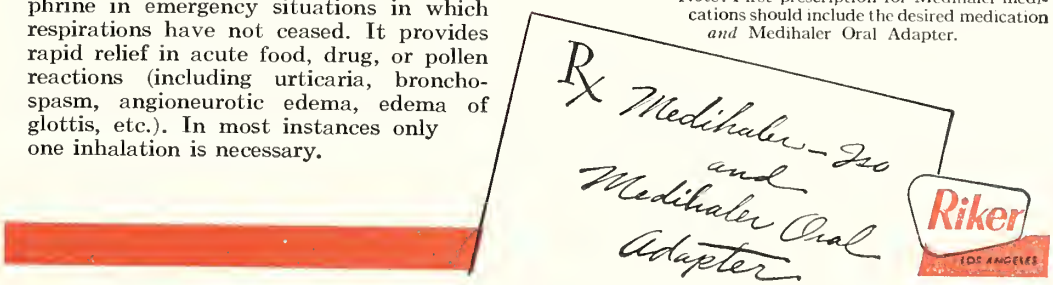
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9. Outline treatment of barbituate poisoning.
10. Give the dosage and mode of action of ammonium chloride.

PRACTICE

1. Give the etiology, the age incidence and the common extra cardiac lesions of acute rheumatic fever.
2. What is the typical diagnostic mark of:
   (a) Extra systole.
   (b) Sinus Arrhythmia.
   (c) Auricular fibrillation.
3. Describe four major diseases of the esophagus.
4. Give the etiology, signs and symptoms of smallpox.
5. Give the signs and symptoms of subacute bacterial endocarditis.
6. Give treatment of typhoid fever, second week of attack.
7. Give treatment of so-called infection of the gall bladder wall without stones or gravel within the cavity of the gall bladder.
8. (a) What are the principal diseases in which a bronchopleural fistula may occur as a complication? (b) Outline the immediate treatment of this medical emergency.
9. Name an agent now used in the treatment of thrombotic or embolic phenomena involvement as a preventive and cure.
10. Describe the therapy of acute left ventricular failure in arteriosclerotic hypertension.

PATHOLOGY

1. List the diagnostic laboratory findings in multiple myeloma.
2. Describe the most characteristic anatomic lesion of typhoid fever.
3. List the causes of cardiac hypertrophy.
4. List the causes of esophageal narrowing.
5. List the common causes of urinary obstruction.
6. List the results of bronchial obstruction.
7. List the typical laboratory and anatomic findings in hyperparathyroidism.
8. Describe a typical contrecoup injury of the brain.
9. Describe a typical lymph node in Hodgkin's Disease (Granuloma).
10. What are the common anatomic sites of actinomycosis?

OBSTETRICS AND GYNECOLOGY

1. List the causes and treatment of post partum hemorrhage.
2. List the positive signs of pregnancy.
3. Give differential diagnosis of an acute exacerbation of chronic pelvic inflammatory disease and acute appendicitis.
4. Give symptoms, diagnosis and treatment of pelvic endometriosis in a patient 25-35 years of age.
5. Name the arterial blood supply ligated in performing an hysterosalpingo-oophorectomy.
6. State the purpose of and outline prenatal treatment.
7. Give method of delivery of a 37 year old primipara with a transverse presentation.
8. How would you differentiate cyclic bleeding from true menstruation?
9. State the functions of the placenta.
10. (a) State the varieties of extra-uterine pregnancy.
    (b) Give the symptoms and treatment of extra-uterine pregnancy.

SURGERY

1. List the symptoms and diagnosis of carcinoma of larynx.
2. List the symptoms, diagnosis and treatment of choledocholithiasis.
3. List causes of hematuria in male patient, 55-65 years of age, and state methods of differential diagnosis.
4. List the symptoms and diagnostic findings of Hodgkin's disease.
5. Give symptoms, diagnosis and treatment of fractured clavicle.
6. Give differential diagnosis of acute appendicitis and gastro-enteritis.
7. List the diagnostic points in intussusception.
8. Give symptoms and treatment of acute peri-tonsillar abscess.
9. While doing a direct hernia operation on a male patient, you recognize that you have opened into the urinary bladder. State a recognized method of handling and treating this condition.
10. Give the symptoms of shock and state methods of treatment.

SPECIALTIES

1. (a) Locate and describe an urethral caruncle.
   (b) How are urethral caruncles handled?
   (c) What would you do for a persistent pyuria?
2. Describe acne vulgaris—what must it be differentiated from and what is the treatment?
3. Describe glaucoma. How is it produced and what is the treatment?
4. List the significant findings and timing of the three states of syphilis.
5. **True or False?**
   (a) A hydatidiform mole is an edematous pigmented skin nevus.
   (b) "Nosology" is the specialty dealing with abnormalities of the nose.
   (c) "Procidentia" is the protrusion of the upper permanent front teeth.
   (d) Nocturnal polyuria may occur as an early sign of decreased renal function.
   (e) Thrush is a form of moniliasis.

PREVENTIVE MEDICINE AND HYGIENE

1. Name four common deficiency diseases and outline the methods of prevention of one of those named.
2. Discuss the etiology, differential diagnosis and methods of control of septic sore throat.
3. Define allergy and discuss its importance in relation to preventive medicine.
4. Show by graphs the trends by months of the morbidity incidence of scarlet fever, typhoid fever and diphtheria and give reasons for the high and low points of incidence.
5. Discuss the advantages and disadvantages from the preventive medicine standpoint of the periodic health examination.

* * *

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

October 2—William Henry Gillard, Cleveland, George Washington University; William Hoffman, Cleveland, Stritch School of Medicine; N. Stanley Lincoln, Columbus, Harvard Medical School; Earl R. Paul, Bellaire, University of Maryland; John V. Munro, Jr., Portsmouth, Yale University; Charles A. Renick, Chillicothe, Harvard Medical School; Donald H. Stuhring, Columbus, Columbia University.

December 19—Dolores-Crystal Arnois, Cincinnati, University of California; James S. Bates, Dover, University of Pittsburgh; Daniel J. Birmingham, Bellaire, Johns Hopkins University; John E. Bloom, Cincinnati, State University of New York; Elliot M. Braverman, Cleveland, Tufts University; Gerald S. Brickman, Cincinnati, Boston University; Marvin Brodie, Cincinnati, Wayne University; Andrew K. Butler, University of Chicago (Rush);

Earl T. Carter, Columbus, Northwestern University; Torrence J. Collier, Sr., Cleveland, Meharry Medical College; Joseph L. Curry, Hahnemann Medical College; Roswell G. Daniels, Cincinnati, University of Rochester; Frederick S. Donaldson, Parma, Tufts College; Albert C. Donohoo, Newark, Long Island College;

Walter J. Gillogley, Cincinnati, Creighton University; Louis D. Green, Cleveland, Meharry Medical College; William F. Havemeyer, Cleveland, University of Buffalo; John J. Johnson, Cleveland, Howard University; Robert W. Kirtley, Cleveland, Indiana University; Rene B. Ledbetter, University of Tennessee; Thomas C. Lloyd, Jr., Cleveland, University of Pennsylvania;

Mary L. McElwee, Oberlin, University of Oklahoma; Robert G. Marquardt, East Liverpool,

(Continued on Page 224)

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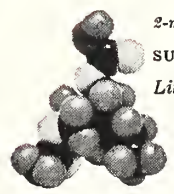
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Cornell University; Anthony R. Minadeo, Cleveland, St. Louis University; Paul W. Pifer, Warren, University of Pittsburgh; Albert Piket, Cleveland, University of Vienna; John J. Plucinsky, Cleveland, Georgetown University; John F. Popken, Jr., Cincinnati, St. Louis University;

Frederick J. Raisch, Canton, Boston University; Aaron S. Raisin, Cleveland, Medical College of South Carolina; Jacob Remler, Dayton, University of Vienna; Richard Sabransky, Akron, The Chicago Medical School; Allen J. Savitt, Cincinnati, Duke University; Burton J. Shapiro, Cincinnati, Indiana University; Erma A. Smith, Cleveland, Rush Medical College; Richard B. Stoughton, Cleveland, University of Chicago; John A. Sturgis, Jr., Cincinnati, Temple University;

Christodoulos B. Theodotou, Columbus, University of Kansas; George Truchly, University of Innsbruck; Duane N. Tweeddale, Cleveland, Creighton University; Eric W. Walter, Wooster, Hahnemann Medical College; Carter C. Wang, Cleveland, Western Reserve University; Richard A. Yamanoha, Sugar Grove, Tulane University; Jess R. Young, Cleveland, St. Louis University.

Columbus Academy and Several of Its Members Cited by Health Council

The Columbus Academy of Medicine and nine of its members were singled out for distinguished service citations Dec. 12 by the Columbus Metropolitan Health Council.

The Health Council is a division of the Council of Social Agencies, which coordinates community planning in the areas of welfare and recreation.

The nine Columbus physicians received their citations for past services as presidents of the Metropolitan Council, which traditionally has as its president a member of the Columbus Academy. The citations were presented by Dr. Richard L. Meiling, President of the Ohio State Medical Association.

The Columbus Academy citation was received by Dr. Edward W. Harris, its president, and was presented by Mrs. Frances Hoffman, agency relations director for the Columbus Hospital Federation and formerly executive secretary of the health council.

In keeping with the council's tradition, Dr. Joseph Hughes was elected its president for 1957.

Those physicians honored for past service include Drs. Russel G. Means, John H. Mitchell, Harve M. Clodfelter, a Past-President of OSMA; Thomas E. Rardin, Frances K. Harding, Grant O. Graves, Robert M. Inglis, Roger E. Heering and Perry R. Ayres.

The Columbus Metropolitan Health Council was organized at the suggestion of the Columbus Academy and been guided in its programs by the Academy since its inception.

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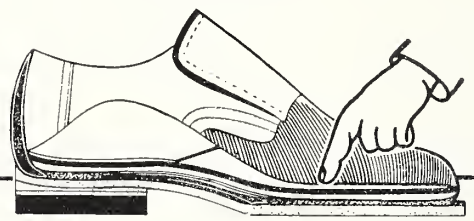
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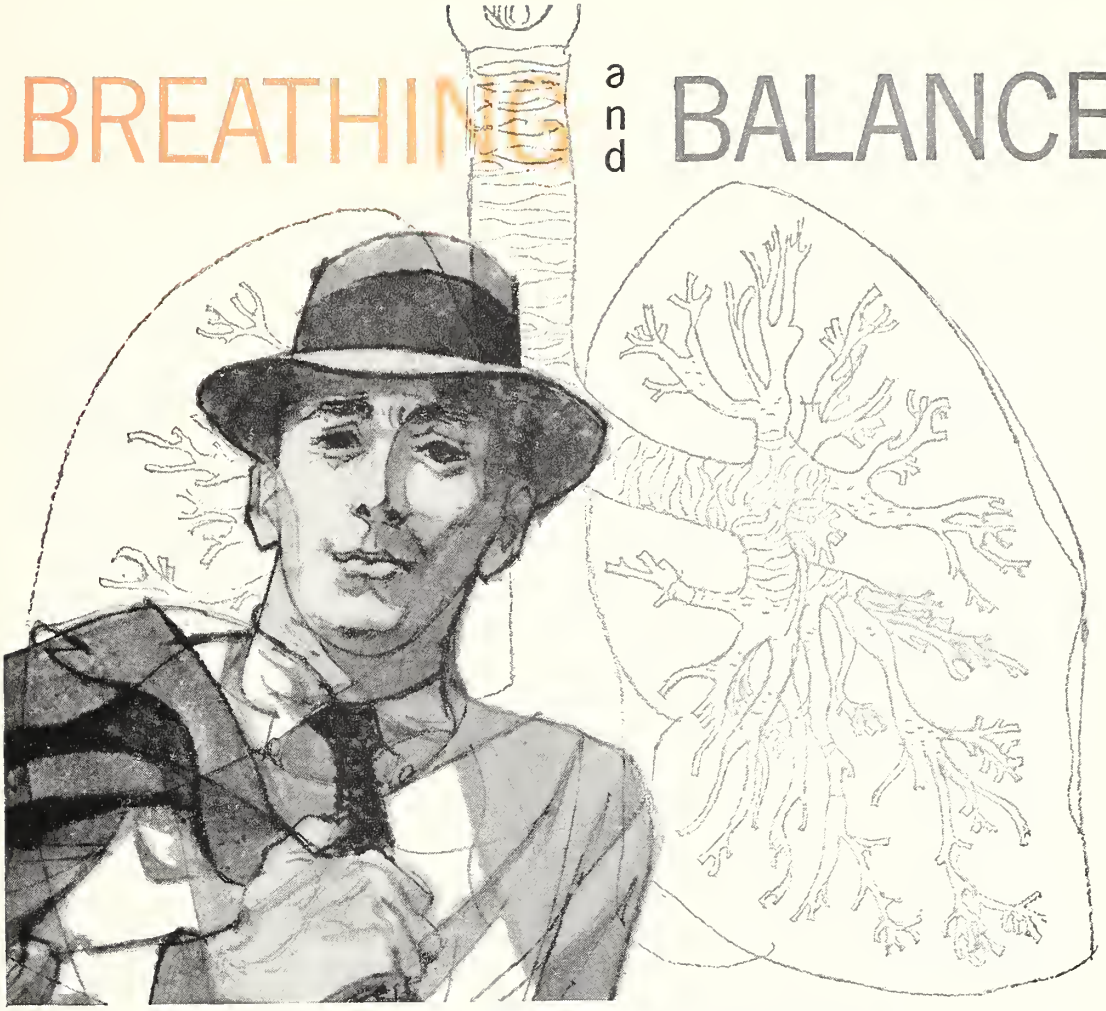
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*Schwartz, E.: New York J. Med. 56:570, 1956.

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In Memoriam . . .

Janis Ciemins, M. D., Warrensville Heights; Latvia University Faculty of Medicine, 1930; aged 50; died December 23; member of the Ohio State Medical Association and the American Medical Association. A former practicing physician in Latvia, Dr. Ciemins came to the United States in 1950 under sponsorship of the Fairmount Presbyterian Church of Cleveland. After doing institutional work, he obtained an Ohio license and opened private practice. He is survived by his widow, two sons, a brother and a sister.

William A. Klann, M. D., Wellington; Eclectic Medical College, Cincinnati, 1929; aged 50; died December 22; member of the Ohio State Medical Association and the American Medical Association. Dr. Klann had been a practicing physician in the South Lorain County area for 23 years. He moved to Wellington from Port Clinton. He was a 32nd degree Mason, a member of the local Chamber of Commerce, the Congregational Church and the Elyria Country Club. Surviving are his widow, two sons and his parents.

Charles A. LaMont, M. D., Canton; Johns Hopkins University School of Medicine, 1908; aged 76; died December 14; member of the Ohio State Medical Association; member of the OSMA Committee on Medical Preparedness and the Ohio Committees on Procurement and Assignment during World War II; diplomate of the American Board of Internal Medicine; Fellow of the American College of Physicians; Past-President of the Stark County Medical Society and the Canton Academy of Medicine. A practicing physician in Canton since 1909, Dr. LaMont was active in many community projects. He participated in the boys' work program of the YMCA for 36 years. He was a member of the Presbyterian Church, the Rotary Club, the Canton Club and was a 32nd degree Mason. Surviving are his widow; two daughters, one of whom is Dr. Marjorie LaMont McGee, of Ross, Calif.; also a son and a brother.

Max C. Labermeier, M. D., Oakley; Eclectic Medical College, Cincinnati, 1917; aged 65; died December 16; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Labermeier had been a practicing physician in the Greater Cincinnati area since 1917, with the exception of time served with the U. S. Public Health Service during World War I. He was a member of several Masonic bodies. Survivors include his widow; a son, Dr. Max C. Labermeier, Jr.; a daughter and a brother.

Robert E. Stoops, M. D., Conneaut; University of Illinois College of Medicine, 1902; aged 78; died December 27; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. A Captain in the U. S. Navy Medical Corps, Dr. Stoops retired in 1946 and opened private practice in Conneaut. Survivors include his widow, a son and a daughter.

Joseph John Weber, M. D., Barberton; Royal Hungarian University, 1922; aged 60; died December 31; member of the Ohio State Medical Association and the American Medical Association. Dr. Weber came to this country in 1924 and located in Bay City, Mich., but moved to Barberton shortly thereafter. He was a member of the Elks Club and the Catholic Church. Surviving are his widow, a son and two sisters.

American Academy of General Practice To Meet in St. Louis, March 25-28

The Ninth Annual Scientific Assembly of the American Academy of General Practice will be held in the Kiel Auditorium, St. Louis, March 25-28.

Details may be obtained from the ACGP office, Volker Blvd., and Brookside, Kansas City 12, Missouri, or from the Ohio Academy of General Practice, 209 S. High St., Columbus 15, Ohio.

During the four-day scientific meeting, the doctors will hear outstanding speakers discuss important subjects including infertility, polio vaccination, and the "neglected" pediatric areas, the eyes, ears, and feet. They will visit 60 scientific and 260 technical exhibits.

Dr. I. S. Ravdin, professor of surgery at the University of Pennsylvania, will moderate a panel discussion of pre- and post-operative care. Dr. Philip Thorek, associate professor of surgery at the University of Illinois and professor of surgery at Cook County Graduate School, will discuss "Intestinal Obstruction." Three other surgeons will highlight advances in vascular, thoracic, and neurosurgery. One afternoon will be devoted to a review of procedures that assure birth of "healthy babies" from "well mothers." This subject is important to family physicians who currently deliver 85 per cent of the nation's children.

The Academy's policy-making Congress of Delegates will convene at 2 p. m., Saturday, March 23. All sessions of the Congress and many social functions will be held in the Sheraton-Jefferson Hotel.

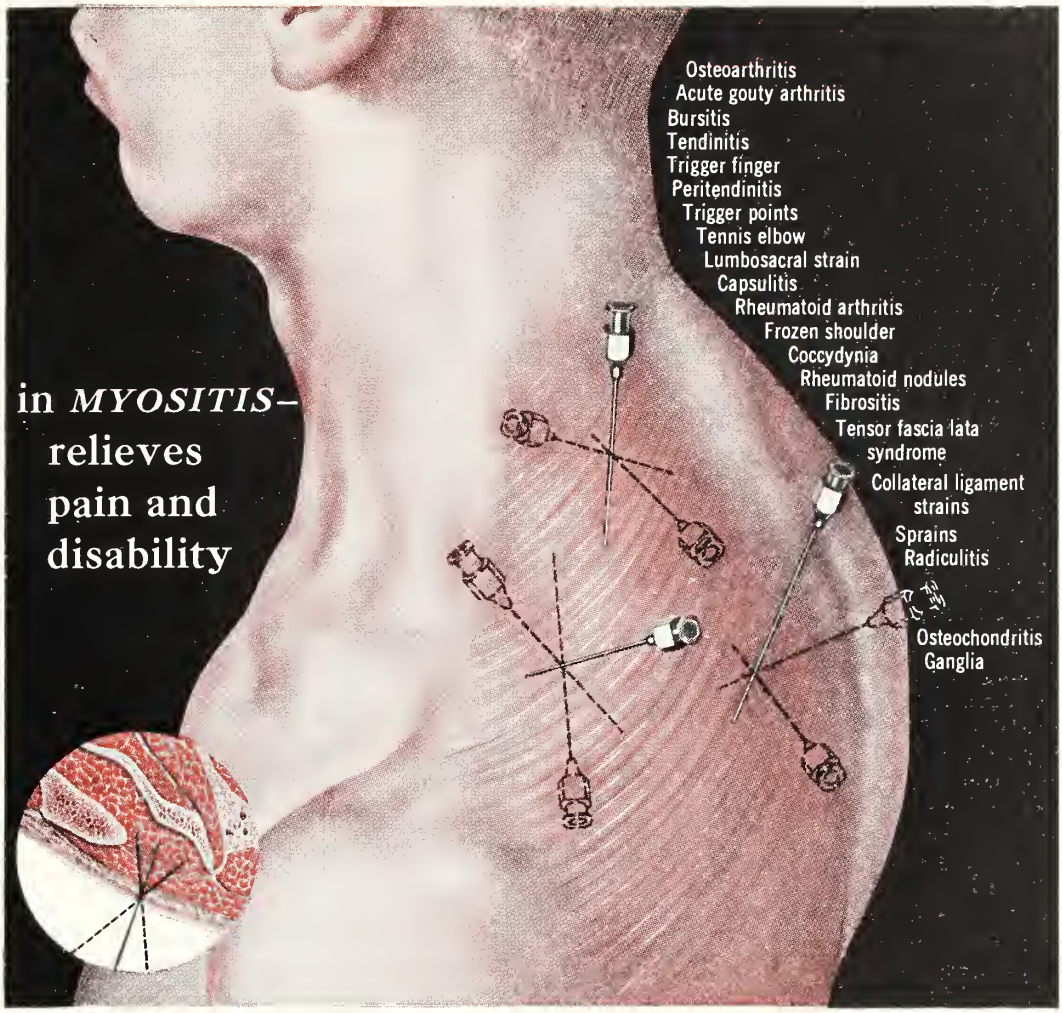
Wednesday evening, March 27, following induction ceremonies for Academy President-elect Malcom E. Phelps, El Reno, Oklahoma, an estimated 3,000 guests will attend a President's reception and dance honoring J. S. DeTar, M. D., Milan, Mich., president of the Academy.

NEW

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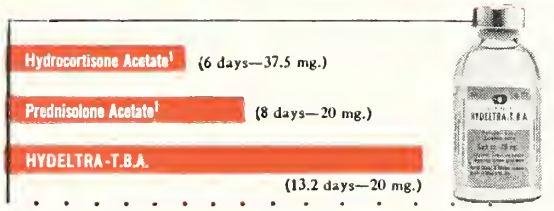
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pain and
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Anti-inflammatory effect lasts longer than that provided by any other steroid ester



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Supplied: Suspension 'HYDELTRA'-T.B.A.—20 mg./cc. of prednisolone *tertiary*-butylacetate, in 5-cc. vials.

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1. Hollander, J. L., *Paper read at conference in New York City, May 31 and June 1, 1955*

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

GOOD CASE RECORDS AN EXCELLENT DEFENSE

Many a physician has lost a malpractice case on the basis of his case records—or better to say the lack of accurate case records.

Defense attorneys have found in many cases that verdicts against their clients would have gone the other way if accurate case histories had been available for introduction as evidence.

For example, an EENT man lost a malpractice suit in which a patient said he had not given permission for a cataract operation on the eye from which the cataract was removed.

The physician lost the verdict because his case records placed the more serious cataract in the right eye three times, and in the left eye four times.

Experienced malpractice attorneys recommend that the physician record every basic fact in every case, particularly names and dates. Also, write out any instructions to balky patients. In some cases, it is wise to put into writing that you do not guarantee a cure.

Keep records on file until the statute of limitations expires. In Ohio, it expires after one year for adults. In the case of an infant, it expires one year after he reaches majority.

GUIDES OF CONDUCT RELATING TO LABORATORIES

A number of items relating to the performance of clinical laboratory procedures were considered recently by the Ohio Society of Pathologists and certain guides of conduct or principles of conduct agreed upon. These will no doubt clarify thinking among that specialty. They should be of interest to all physicians, as they are principles which affect professional relationships.

This subject was covered in a letter sent to all members of the OSP by Dr. Philip Wasserman, immediate past-president of the organization. A major excerpt from that communication follows, listing the five principles and an explanation of No. 5:

> "1. The acceptance of cytology smears and tissue from lay laboratories is a violation of the code of ethics of the College of American Pathologists.
>
> "2. Since it is unethical to accept such specimens there obviously can be no problem about billing.
>
> "3. It is equally unethical to accept clinical laboratory material for examination from a lay laboratory.
>
> "4. It is unethical to arrange for the giving of discounts for quantity laboratory work or for the performance of laboratory work on a contract basis since it may well become a form of fee splitting.
>
> "An additional item has been considered and agreed upon but before stating it as item 5, I would like to preface it with a note. This item relates to the difficult problem of billing physicians for laboratory examinations when they bring in the specimens or mail in the specimens to the laboratory. Under these conditions the laboratory does not have direct contact with the patient nor does the patient usually have knowledge or contact with the laboratory. This problem is particularly of concern in areas where a large number of specimens are mailed in, as for instance in areas other than large urban areas. To bill patients directly for such work undoubtedly would often lead to confusion and recrimination and possibly disregarding of billings by the patients involved. It is therefore felt by the Society that for the moment, at least, pending possible further study the following may be looked upon as a fifth guiding principle.
>
> "5. It is proper for a physician operated laboratory to send bills to another physician for laboratory examinations performed upon the second physician's patient, under such circumstances where there is no direct contact initially between the patient and the laboratory. It is recommended, however, that wherever possible direct billing to the patient should occur and this, it is felt, can frequently be accomplished through the aid of the referring physician. It is suggested for instance that the billing which is made to the referring physician could be endorsed by him and sent on to the patient, thereby making the billing in some measure a direct billing."

THE CLINICAL CASE AND INSURANCE

In the December issue of the Columbus Academy of Medicine Bulletin there appeared a most provocative editorial, captioned "The Clinical Case." Reproduced below, it discusses a situation which is becoming more prevalent in most areas where there are so-called teaching hospitals. It calls for clarification and correction. Read it. Study it. The situation may prevail in your community. What should—can—be done about it?

"It is a trite expression that editorial writers are people who 'point with pride and view with alarm.' With this in mind, there is prevalent a condition which we truly view with alarm. The situation, which is not local, has caught the fancy of many, and is growing in popularity in our community.

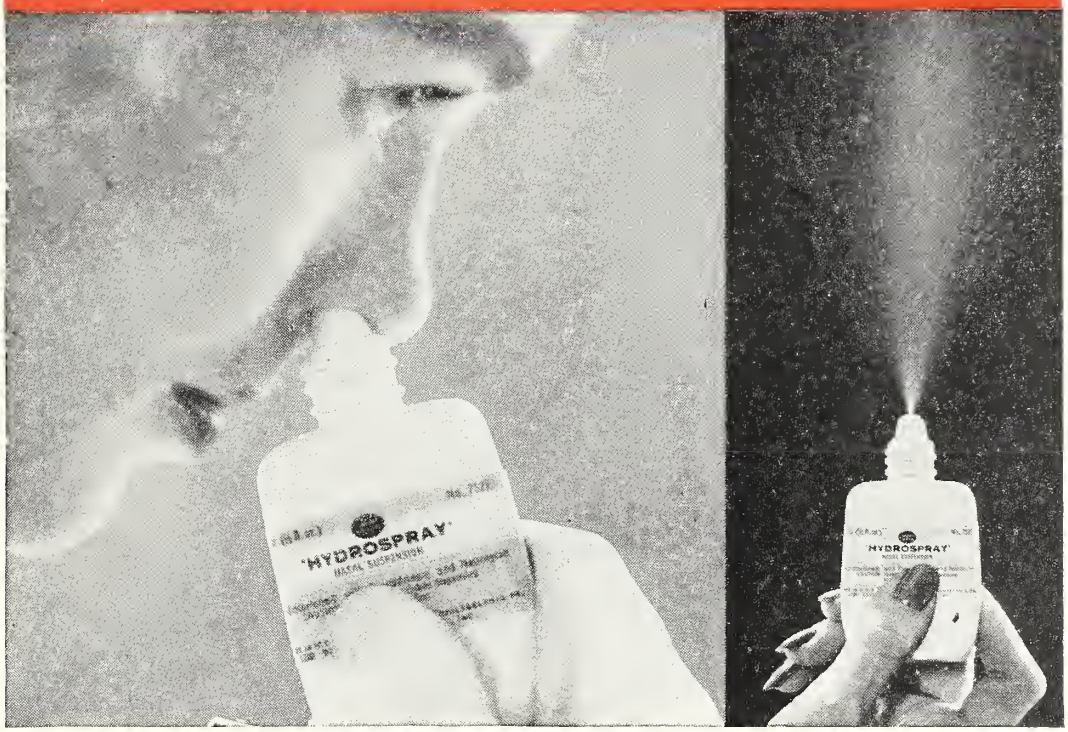
"But first, what is a clinical patient? It has always been our concept, in tradition and training, that a clinical patient is one who has a pressing medical (or surgical) problem and is

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Anti-inflammatory—
Decongestant—Antibacterial

MAJOR ADVANTAGES: New synergistic anti-inflammatory, decongestant and antibacterial formula. High steroid content assures effective response.



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SUPPLIED: In squeezable plastic spray bottles containing 15 cc. HYDROSPRAY, each cc. supplying 1 mg. of HYDROCORTONE, 15 mg. of PROPADRINE Hydrochloride and 5 mg. of Neomycin Sulfate (equivalent to 8.5 mg. of neomycin base).

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REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* 60:431, Oct. 1954.

financially unable to have this problem attended on a private basis.

"As such, this patient receives treatment by the younger student physician under the guidance of competent staff doctors. These patients receive treatment with the same careful deliberation and dignity as the most respected and affluent member of the community.

"The elder staff physician responsible for the ultimate care, has received this trust as an honor and privilege of his professional status, rather than as an obligation. Doctors have always abhorred the concept that clinical patients are 'guinea pigs,' and have gladly accepted this responsibility. The main basis of our medical education depends on bedside training, usually with the clinical patient.

"What then determines what constitutes a clinical patient? Most hospital administrators have established a set of financial standards and declared thusly, that people below a certain financial level shall qualify as clinical, and all others as private patients. There is no agreement as to this arbitrary financial level. If a hospital were unable to obtain more patients for teaching the student physician, it would be a simple matter of changing the financial standards. But the problem which we sincerely 'view with alarm' is the assumption and pre-emption of private insurance fees belonging to the clinical patient, under one guise or another. The larger the teaching hospital, the more flagrant is the act.

"Why do people have surgical and medical insurance? It seems obvious that these insurance programs are primarily established so that individuals may have medical or surgical treatment by the physician of their choice. This is the only reason we can see why anyone would voluntarily purchase such insurance. No matter what medical insurance the individual has, be it Blue Shield, company, or private, it was never conceived or purchased to establish a medical or surgical rotary fund, to support a research program, to finance residents to a convention, or add a teaching chair. These insurance programs are sponsored and owned for but one purpose: *to finance medical or surgical needs when necessary on a private basis.* To signify that a patient is clinical, and then to take over insurance fees from this same patient under one guise or another contradicts our claim that private coverage obviates socialized medicine, and is morally and ethically wrong!

"There must be clarification of this situation. The medical community and not the individual hospital should determine when a patient is clinical. All phases of teaching programs have to maintain a strict hands-off policy on all private insurance and look elsewhere for funds; else we shall defeat the very basis and principles of private practice. The true clinical patient will still be treated with the same reverence and respect as did our elders, and their elders."

"UNLESS DOCTORS WAKE UP"—

With the 85th Congress and the 102nd Ohio General Assembly currently in session, words of caution from AMA Law Director Joseph Stetler are particularly timely.

In an article in the December 21 issue of *Philadelphia Medicine*, Mr. Stetler sums up the Washington picture as follows:

"* * * With a basically 'friendly administration' there were more bills passed which are adverse to the private practice of medicine during the 84th Congress than in any other two-year period in our history.

"Why? Is our philosophy wrong? Is our mechanism for expressing our views on legislation archaic? We believe the answer to both these questions is an emphatic **NO!**

"I believe the answer is as simple as this: Our adversaries have increased their efforts, their work, and the tempo enormously. We have not kept pace. Despite the increased legislative efforts of doctors and their wives they are not even operating at one-tenth of their legislative potential.

"Unless doctors wake up and become concerned with national medical legislative affairs and do something about it personally, it will make no difference

"(a) What kind of leadership you have

"(b) What the caliber of your staff may be

"(c) What type of mechanism you employ

"The 85th, the 86th, and all succeeding Congresses will be a repetition of the 84th and the passage of additional adverse bills will be inevitable."

To which we add our amen.

GOOD PROJECT; EVERY SOCIETY SHOULD COOPERATE

Questionnaires to determine the scope of activity in various areas—including public education, community service, society projects, meetings, personnel, and finances—are being distributed by the American Medical Association to all county medical societies. This fifth biennial survey of county medical society activities is being undertaken by the Council on Medical Service and the Department of Public Relations with the assistance of other AMA departments. More than 1,200 county societies supplied information for the 1955 survey, and it is hoped that an even larger number will complete the 1957 questionnaire.

Here's hoping all the County Medical Societies in Ohio will give this project their full support. The compilation which will result will offer some great ideas for future planning as it will show what societies all over the nation are doing. We learn by knowing what others are doing. They learn by knowing what's going on in Ohio societies.

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Activities of County Societies . . .

First District

(COUNCILOR: FRANK H. MAYFIELD, M. D., CINCINNATI)

CLINTON

Dr. John K. Williams was elected president of the Clinton County Medical Society at the December 4 meeting in Wilmington. He succeeds Dr. David Hamilton. Dr. Thomas M. Faehnle, of Sabina, was elected vice-president, and Dr. Edmond K. Yantes, Wilmington, secretary-treasurer.

The meeting followed luncheon at the General Denver Hotel and doctors heard a program by Dr. Harry Ezell, assistant professor of obstetrics and gynecology of Ohio State University who spoke on treatment of carcinoma of the uterus.

CLERMONT

Dr. Charles McNeill Simmons, Bethel, was elected president of the Clermont County Medical Society for 1957, at the annual meeting of the organization held in Milford on December 12. He succeeds Dr. A. Gordon Schulze, of Amelia.

Dr. Richard Carr, Williamsburg, was named vice-president, and Dr. John Crone, Milford, was re-elected secretary-treasurer. Dr. Carl A. Minning, Williamsburg, was elected delegate to the OSMA with Dr. Crone as alternate.

The Society went on record as backing unanimously a program to get all children, at least through the third grade, immunized against polio, diphtheria, tetanus, whooping cough and smallpox, after a Board of Health study was presented showing a very small percentage of children with preventive treatment. An appeal was made by the new president through the local newspaper for such a program.

HAMILTON

A regular meeting of the Academy was held on January 15 in the College of Medicine Auditorium. The subject, "Life in a Germ-Free World," was discussed by Professor James A. Reyniers, research professor of bacteriology and director of Lobund Institute, University of Notre Dame.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

MIAMI

The Miami County Medical Society met on January 3 following luncheon at the Ft. Piqua Hotel, Piqua. Guest speaker was Dr. John Holzaepfel, Ohio State University College of Medicine, Columbus, who spoke on the subject, "Office Gynecology."

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

LOGAN

A case of bowel intussusception in an infant was presented by Dr. George Gensemer at the January meeting of the Logan County Medical Society held in the dining room of the Mary Rutan Hospital.

The officers for the ensuing year are as follows: President, Dr. Charles Thompson; vice-president, Dr. Paul Hooley; secretary-treasurer, Dr. Charles Browning.—Charles A. Browning, Jr., M. D., secretary-treasurer.

MARION

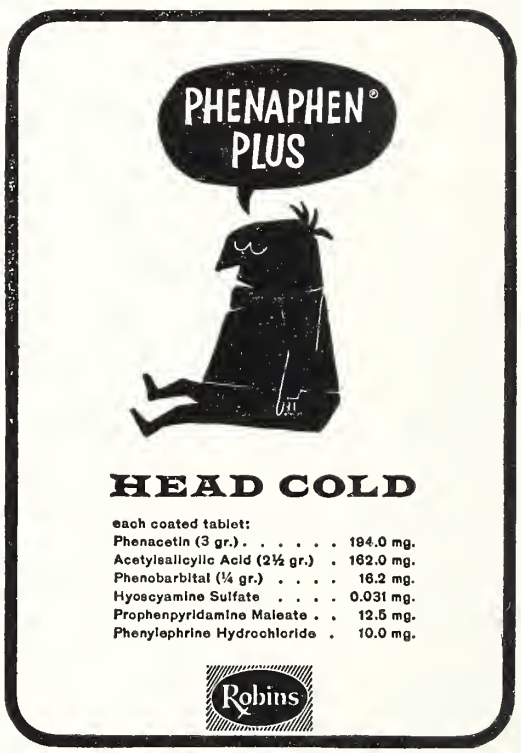
Dr. Carl W. Sawyer was honored at the December 4 meeting of the Marion County Academy of Medicine, when he was presented the 50-Year Pin and Certificate of the Ohio State Medical Association. Dr. James R. Jarvis, Van Wert, Councilor of the Third District, made the presentation. Dr. Sawyer is a well-known Ohio physician both for his practice of many years standing in the Marion area and for his association with the Sawyer Sanatorium.

Fourth District

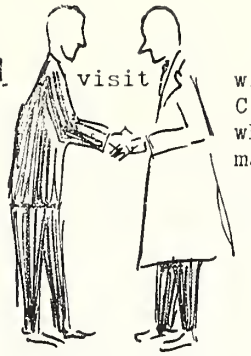
(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The 55th annual meeting of the Academy of Medicine of Toledo and Lucas County was held in the Commodore Perry Hotel on January 9. The President's Address was given by outgoing

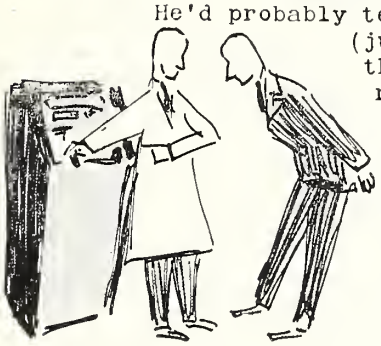


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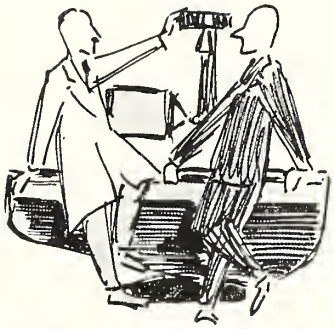
He'd probably show you how good a radiograph he gets every time





He might even touch on the peace-of-mind that comes of having a local Picker office so near, with a trained Picker expert always on call for help and counsel

and there'd be no mistaking the light in his eye when it falls on the handsome big-name unit whose fine appearance adds so much to the impressiveness of his office.



P.S. Somewhere along the line the matter of price would come up ... he'd most likely comment on how little he paid to get so much. Or he might even be among those who rent their x-ray machine (Picker has an attractive rental plan, you know).

P.P.S. Next best thing is to call your local Picker man in and let him tell you about this great new machine (find him in your 'phone book) or write Picker X-Ray Corporation, 25 South Broadway, White Plains, N. Y.

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Columbus 11, Ohio, 2330 Hiawatha Park
Toledo 7, Ohio, 844 Sawyer Road
Canton, Ohio, 2435 41st St., N.W.
Dayton, Ohio, 933 Porter Avenue

President Byron G. Shaffer. His talk emphasized the necessity of a progressive public education program to strengthen the doctor-patient relationship.

Three veteran physicians were honored at the occasion. They are Dr. William G. Gardiner, Dr. Warren J. Howard and Dr. C. W. Waggoner. 50-Year Pins and Certificates of the Ohio State Medical Association were presented to them by Dr. Paul E. Orr, Perrysburg, Fourth District Councilor.

President for 1957 is Dr. Max T. Schnitker, President-elect is Dr. Harvey C. Gunderson; Dr. Gordon M. Todd, was re-elected secretary, and Dr. Shaffer was named to the board of trustees.

Dr. R. C. Young, Atlanta, Ga., was guest speaker and spoke on "Why I Am Proud To Be an American."

The General Practice Section of the Toledo Academy met in the Academy Building on January 18. Dr. Samuel Saslaw, associate professor of medicine and bacteriology, Ohio State University, discussed "Commonly Missed Infectious Diseases."

The Surgical Section met on January 25. The subject was "Medical and Surgical Problems of the Upper Abdomen with Emphasis on Diagnosis and Management; the speaker, Dr. Stanley O. Hoerr, Department of Surgery, Cleveland Clinic.

PUTNAM

December meeting of Putnam Society was held at Hotel Dumont, Ottawa, December 4. Guest speaker was Dr. A. Frank Portmann, Lima Surgeon, whose subject was Electrolyte and Fluid Balance.

Dr. Portmann told his audience that texts on this subject contain much theoretic data which no man in clinical practice can be expected to assimilate. He stressed the importance of body fluid evaluation in acute febrile and other conditions. Using blackboard illustrations, he outlined a much simplified approach in hospital emergencies and some cases treated at home. He discussed the various conditions in which the need for fluid balance correction may be determined at once from clinical signs alone.

In the discussion which followed, Dr. Portmann cited cases of circulatory and metabolic disturbance complicating surgery. These cases, he said, demand the most meticulous care in determining the disturbed fluid balance present. Many repeated tests may be required, some of them highly technical and costly. This should be made known to the patient's family, and the need for the unusual procedures explained.—H. N. Trumbull, M. D., correspondent.

WILLIAMS

Dr. R. A. Gilreath, Bryan, was elected president of the Williams County Medical Society at the annual meeting in Bryant December 18. Also elected for 1957 were Dr. David Brown, Stryker,

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. . . a private resident school for children of average or superior intelligence whose psychological difficulties impair their learning abilities and school progress.

. . . enrolling children from seven to fourteen years of age. Coeducational. Small classes. Remedial reading. Brochure on request.

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contributing to . . . a world-wide acceptance unmatched in modern intravenous anesthesia

Twenty years of use, over 2500 published reports—seldom in the history of medicine has a single drug enjoyed the acceptance accorded Pentothal Sodium. This modern intravenous anesthetic is more than just thiopental sodium. It is thiopental sodium *plus* the most exacting controls . . . *plus* adaptability to widely varying practices . . . *plus* the most thoughtfully planned dosage forms. *Priceless pluses,* these, making Pentothal Sodium an agent of choice the world over in intravenous anesthesia. Abbott

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vice-president, and Dr. R. W. Dilworth, Montpelier, secretary-treasurer.

Chosen as delegate to the Ohio State Medical Association convention was Dr. Paul Meckstroth, Bryan, with Dr. John R. Riesen, Bryan, as alternate.

Guest speaker for the meeting was Dr. Paul F. Orr, Perrysburg, Councilor of the Fourth District of the OSMA.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

CUYAHOGA

The Section on Surgery of Trauma of the Academy of Medicine of Cleveland met on December 14. Following are subjects and speakers: "Tendon Injuries in the Finger," Dr. Elden C. Weckesser; "Fracture Dislocations of the Finger," Dr. Sam Stubbins; "Traumatic Injuries of Finger Volar Skin Loss," Dr. Darrell T. Shaw.

The Experimental Medicine Section of the Academy met with the Cleveland Section of the Society for Experimental Biology and Medicine. The following physicians participated speaking on the subjects indicated: Dr. Eli Gold, "Infections with Adenoviruses"; Dr. Robert C. Haynes, "Mechanism of Action of ACTH"; Dr. Harold P. Roth, "Effect of Vagotomy on Motility of the Small Intestine." The following persons participated in a study on the mechanism of action of the oral hypoglycemic agents used in the treatment of diabetes mellitus: Drs. M. S. Mackenzie, Maxine Cammarn, J. W. Craig, W. R. Drucker, Max Miller and Mr. Hiram Woodward, Jr.

A combined meeting of the Academy of Medicine of Cleveland and the Cleveland Surgical Society was held on January 18. Cocktail hour and dinner was followed by the program. A symposium on the Sympathetic Nervous System —Recent Advances, was conducted under the chairmanship of Dr. Samuel O. Freedlander. Those participating, with the phases of sympathectomy on which they spoke, were Dr. Fiorindo Simeone, professor of Surgery, Western Reserve, "Peripheral Vascular Disease"; Dr. William D. Holden, professor of surgery, Western Reserve, "Sympathetic Dystrophy," and Dr. Keith S. Grimson, professor of surgery, Duke University, "Hypertension and Visceral Pain."

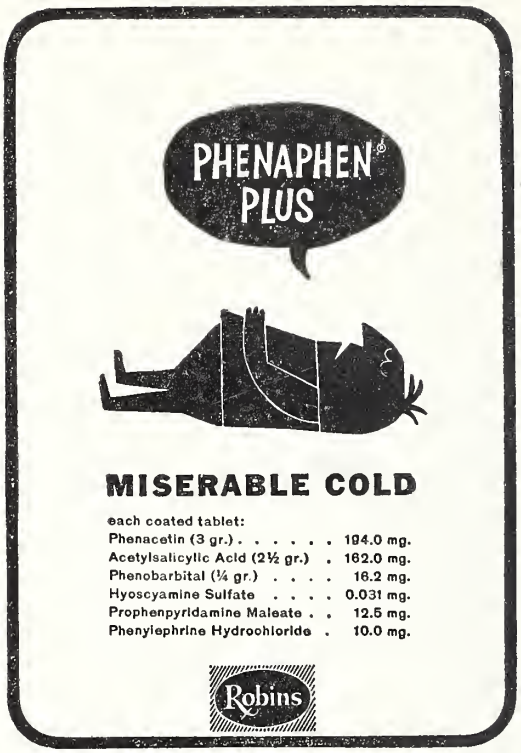
Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

Mahoning County Medical Society members voted to raise their rates January 1, at the annual business meeting on December 18 in the Elks' Club of Youngstown.

Office calls advanced from $4 to $5, house calls from $5 to $7 between the hours of 8 a. m. and







Tastiest way to dissolve sore throat symptoms

TROCHES

'HYDROZETS'

(HYDROCORTISONE-BACITRACIN-TYROTHRICIN-NEOMYCIN-BENZOCAINE TROCHES)

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Other indications: As adjunct therapy in aphthous ulcers, acute and chronic gingivitis and Vincent's infection.

Supplied: Vials of 12 troches.

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Dr. Stephen W. Ondash succeeded Dr. G. E. DeCicco as president. Dr. A. A. DeTesco was named president-elect; Dr. M. W. Neidus, secretary; Dr. Alex Phillips, treasurer. Delegates to the state convention are Dr. Fred Schlecht, Dr. Asher Randell and Dr. Paul Mahar. Representative to the Associated Hospital Service is Dr. Joseph Ranz.—Information from Dr. Clyde K. Walter, correspondent.

SUMMIT

Dr. Elmer Hess, immediate Past-President of the American Medical Association, was guest speaker at the January 8 meeting of the Summit County Medical Society in Akron. His subject was "Treatment of Pyuria or Genito-Urinary Dysfunction."

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

The Belmont County Medical Society and Auxiliary met at the Belmont Hills Country Club on January 17 for an afternoon program followed by dinner. The speaker was Dr. David Gillespie, Department of Chest Diseases, Cleveland City Hospital, whose subject was "Dyspnea and Its Related Causes."

HARRISON

Members of the Harrison County Medical Society and their wives honored Dr. Joseph McElhatten, of Freeport, at a banquet at the Cadiz Country Club on December 11 for his 50 years of practice as a physician.

He was presented the 50-Year Pin of the Ohio State Medical Association by Dr. Dwight C. Pettay, of Cadiz, president of the Society, and the OSMA citation by Dr. Robert E. Hopkins, Coshocton, Councilor of the Seventh District.

Among those who spoke were Dr. Hopkins and Representative A. H. Milleson, as well as Dr. McElhatten.

Dr. McElhatten is a native of Pennsylvania and graduated from the University of Maryland in 1904. He started practice at Centerville, West Virginia, moved to Ohio in 1906 and practiced at Londonderry. He moved to Freeport in 1926. He is a past-president of the local Medical Society, for many years was president of the board of directors of the Freeport State Bank and has served many years on the local school board.

TUSCARAWAS

The Christmas meeting and dinner of the Tuscarawas County Medical Society and Auxiliary was held at the Union Country Club on December 5, with an attendance of 70. Mrs. Pilloff, as retiring president of the Auxiliary, and Dr. Reed as retiring president of the Society, were among those who spoke.

New officers for 1957 are: Dr. Paul Hahn, president; Dr. William Roche, president-elect; Dr. Arthur Stevenson, secretary-treasurer; Dr. H. Reed, member of the Board of Censors for three years; Dr. Joseph Hamilton, delegate; and Dr. R. Rinderknecht, alternate.

It was announced that Dr. Harold Wherley took part in conducting a first aid course under auspices of the County Red Cross with the help of other doctors.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

Six physicians were honored at the December 5 meeting of the Columbus Academy of Medicine, which was the annual dinner-dance, held this season at the Valley Dale in Columbus.

Presentations of the 50-Year Pin and Certificate were made in person to Dr. William S. Van Fossen, Dr. Albert B. Landrum and Dr. E. V. Reutinger. Presentations were made by Dr. Edwin H. Artman, Chillicothe, Councilor of the Tenth District, and Dr. E. W. Harris, Columbus Academy president.

Honored in absentia were Dr. H. M. Brundage, Dr. Halbert B. Blakey and Dr. George H. Bonnell, Sr.

Cook County
Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES—WINTER AND SPRING, 1957

SURGERY—Surgical Technic, two weeks, Feb. 11, Feb. 25. Surgery of Colon & Rectum, one week, Mar. 4. General Surgery, one week, Feb. 11. Surgical Anatomy & Clinical Surgery, two weeks, Mar. 11. Basic Principles in General Surgery, two weeks, Apr. 8. Treatment of Varicose Veins, two days, Mar. 4. Fractures & Traumatic Surgery, two weeks, Mar. 11. Gallbladder Surgery, three days, April 8. Surgery of Hernia, three days, April 11.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Feb. 11. Vaginal Approach to Pelvic Surgery, one week, Feb. 4. General & Surgical Obstetrics, two weeks, Feb. 25.

MEDICINE—General Review Course, two weeks, Apr. 29. Electrocardiography & Heart Disease, two-week basic course, Mar. 11. Gastroscopy, two weeks, Mar. 18.

RADIOLOGY—Diagnostic X-Ray, two weeks, Feb. 4, Apr. 29. Clinical Uses of Radioisotopes, two weeks, May 6. Radioactive Iodine, one week, Apr. 1.

UROLOGY—Two-Week Course, Apr. 1. Cystoscopy, ten days, by appointment.

PEDIATRICS—Two-Week General Course, May 13.

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Activities of Woman's Auxiliary . . .

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Corresponding Secretary—Mrs. Earl Young, 170 Brookline Ave., Youngstown

Past-President and Finance Chairman—Mrs. Karl Ritter, 1420 Shawnee Rd., Lima

---

ALLEN

Members of the Auxiliary to Allen and Lima County Academy of Medicine has for one of its projects, work in geriatrics. Toward this end the Auxiliary since 1951 has provided monthly programs and refreshments for the Best Years Club in cooperation with the YWCA. The co-chairmen of the project this year are Mrs. David Steiner and Mrs. S. J. Novello. The Best Years Club whose members must be 65 years of age or older, also have projects such as quilting and sewing garments for youngsters.

During December this Auxiliary worked sorting contributions of drugs before the supplies were packed and sent to Hungarian refugees. Auxiliary members collected sample drugs from physicians and other sources and took them to the county Red Cross chapter for sorting and shipping. Mrs. Emmett Murray and Mrs. D. W. English are co-chairmen of this project.

ASHTABULA

The annual Christmas dance of the Ashtabula Medical Auxiliary was held December 8 at Hotel Ashtabula. Proceeds benefitted the Auxiliary's student nurses scholarship fund. Mrs. G. D. Sherrill was chairman and Mrs. James O'Bell, cochairman for the dance. On their committee were Mrs. C. J. Streicher, Mrs. Charles Suttles, Mrs. Harmon Tidd and Mrs. A. F. Urankar.

BELMONT

The annual Christmas party and dinner of the Belmont County Medical Society was held December 20 at the Belmont Hills Country Club.

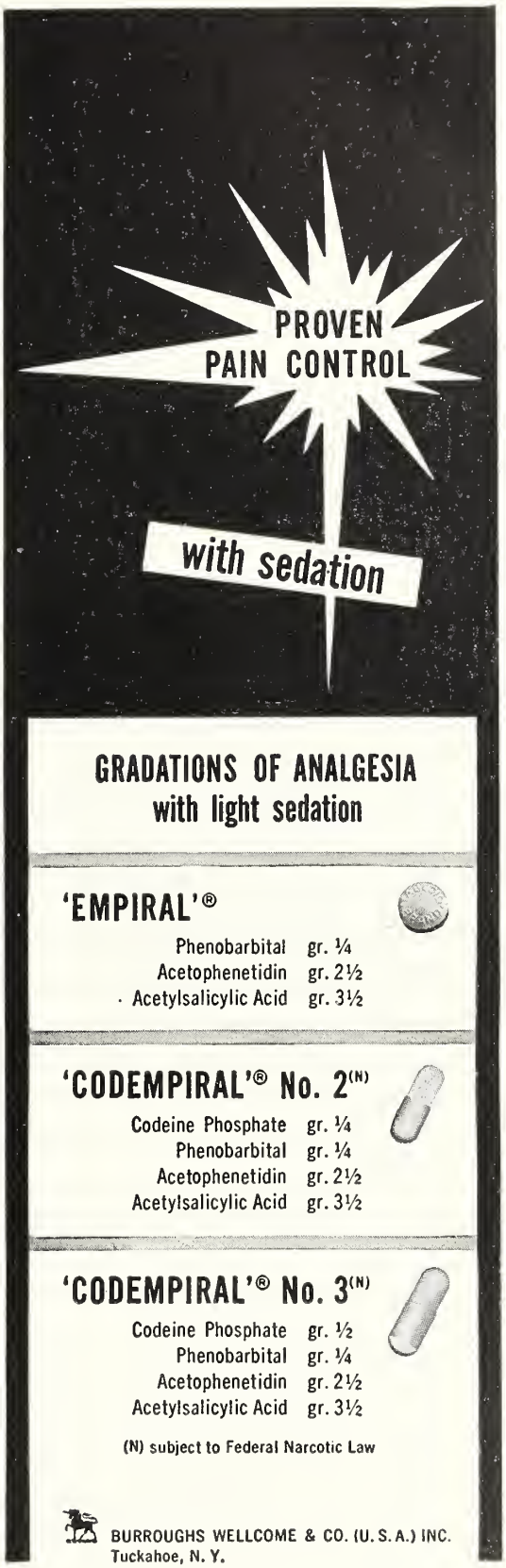
The Auxiliary held a short business meeting with Mrs. A. J. Antalis presiding. A gift of money was donated for Christmas treats for patients at the Belmont County Sanatorium. Gaily wrapped gifts given by the members for the County Home for the Aged were packed in a Christmas box to be delivered to the home.

Forty-five persons were in attendance.

CLARK

The Woman's Auxiliary to the Clark County Medical Society held a formal dinner dance in the Springfield Country Club on December 8.

The doctors were guests of their wives at the





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*Bodkin, L.G., and Ferguson, E.A., Jr.: Successful Ointment Therapy for Pruritus Ani, Am. J. Digest. Dis. 18:59 (Feb.) 1951.

annual affair. As their guests the Auxiliary also had the interns and their wives of both Springfield City and Mercy Hospitals.

A huge Christmas card on display served as a decoration and was used to promote the Auxiliary's philanthropy fund. In place of the annual exchange of Christmas cards, members were asked to donate to the fund. Hostesses for the affair were Mrs. John Harley and Mrs. Robert McLemore.

CLINTON

The Woman's Auxiliary to the Clinton County Medical Society was hostess to a Christmas tea given on December 10 for members of the hospital staff and personnel.

Guests were greeted by Mrs. V. E. Hutchens. Mrs. J. H. Frame and Mrs. R. H. Vance arranged the pre-holiday event.

COLUMBIANA

Novelty events and a visit from Santa highlighted the dinner dance December 15 at the East Liverpool Country Club arranged by the Woman's Auxiliary to the Columbiana County Medical Society. Seventy attended the dinner.

The committee in charge included Mrs. William S. Banfield, chairman, Mrs. K. W. Turner, Mrs. Janis Lauva, Mrs. John A. Fraser, Mrs. Charles A. Gerace, Mrs. J. Fraser Jackson and Mrs. H. F. Banfield.

HARDIN

The Mistletoe Ball, which is held annually by the Hardin County Medical Auxiliary was a social event on December 28. The Auxiliary introduced this affair to Kenton in 1948.

Each year the total donation is equally divided between Hardin Memorial and San Antonio Hospitals with the total sum received from the ball in the past eight years amounting to $7,645.50.

Mrs. William Binkley and Mrs. Robert Zeis were co-chairmen this year.

LUCAS

The Woman's Auxiliary to the Academy of Medicine of Toledo met on November 28 in the Academy Building. The Mental Health Committee and Live Issues Study Group had a combined meeting to hear Dr. Bernard Huss speak on "Retarded Children." Mrs. Josina Lott of Lott Day School also showed slides, taken of the children in the school.

Mrs. Bernhard Steinberg, Mrs. Joseph Sink and Mrs. M. R. McGarvey were hostesses for the meeting.

MONTGOMERY

The Woman's Auxiliary to the Montgomery County Medical Society had its Christmas luncheon on December 18. Mrs. John Groff spoke on the subject of "Madonnas." She and her husband have made this a special hobby.

Also at this luncheon, the past presidents were honored and presented with pins—a gold caduceus on a silver disc. Those thus honored were: Mrs.

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Alva D. Cook, Mrs. John Groff, Mrs. Robert Zipf, Mrs. Harold James, Mrs. Richard Schneble, Mrs. Harvey Staton, Mrs. C. Clarkson Payne, and Mrs. E. Wallace Smith.

TUSCARAWAS

Thirty-five members of the Tuscarawas Medical Auxiliary and their husbands enjoyed a Christmas dinner party on December 12 at the Union Country Club.

There was a short business report made by the Auxiliary president, Mrs. Piloff, and one by the county medical society president, Dr. H. E. Reed.

Mrs. Paul Hahn served as chairman of the affair, with Dr. Rinderknecht and Mrs. M. W. Everhard on the program committee. Others on the committee were Mrs. Crawley, Mrs. Stevenson, Mrs. Johnston, and Mrs. William E. Hudson.

South Dakota Will Combine Medical Program with Pheasant Hunt

The Hunter's Fall Medical Meeting sponsored by the South Dakota State Medical Association will be held at Mitchell, South Dakota, during the first five days of pheasant hunting season in October, 1957.

The program is set up for out-of-state doctors and will feature—morning scientific sessions, afternoon hunting and evening scientific and social sessions.

The registration fee is set at $100.00 which will cover the out-of-state hunters license, hunting guides, reserved hunting areas, several social events, and the scientific program. Motel and hotel space has been reserved, but registration is limited to the available housing.

The affair is not stag, but wives who hunt must pay the full registration fee and those not hunting, three-fourths of it. (This is necessitated by the tight housing situation.)

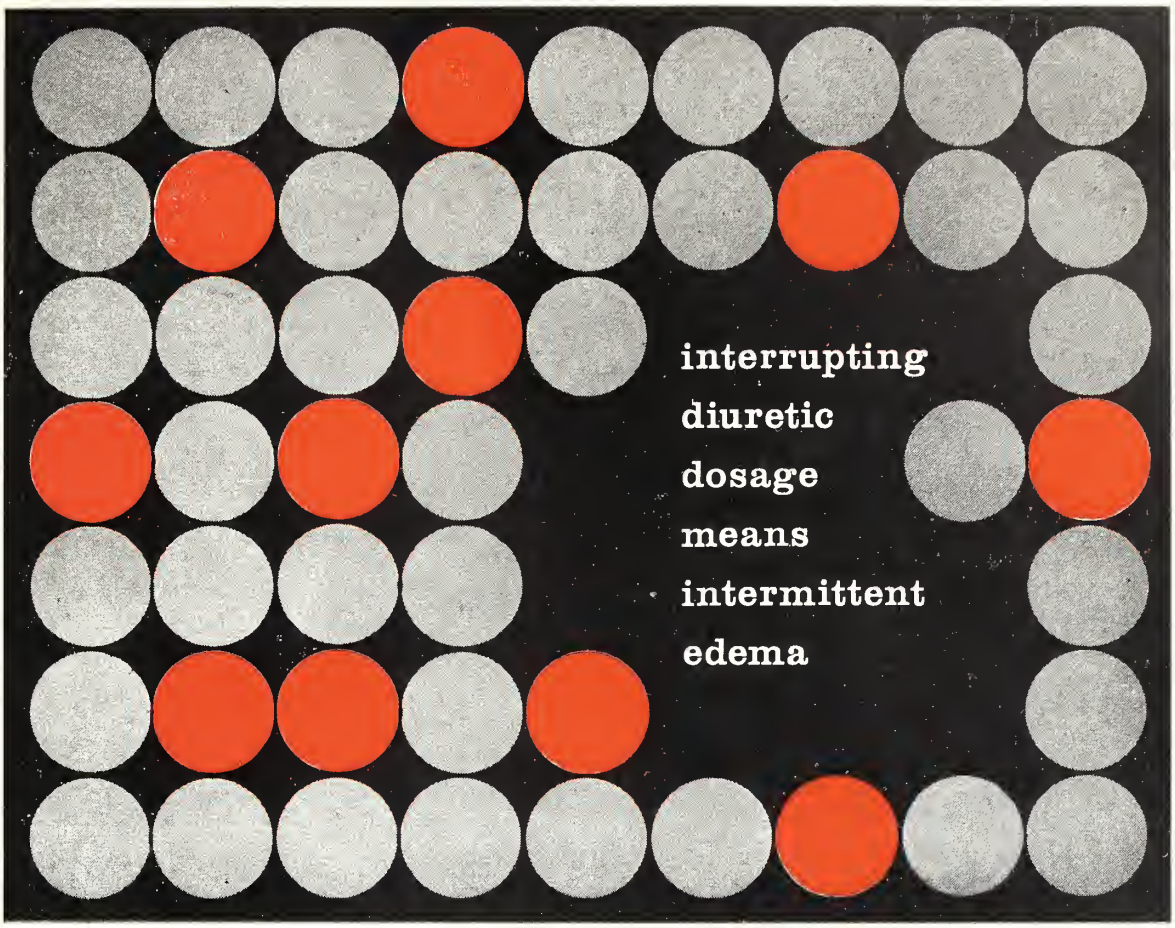
For details and reservations write to Mr. John C. Foster, executive secretary, South Dakota Medical Association, 300 First National Bank Bldg., Sioux Falls, South Dakota.

Mechanics of Digestion Is Exhibit Subject

Plans are under way by AMA's Bureau of Exhibits for a new health education exhibit showing the anatomy and mechanics of digestion. Colorful three-dimensional anatomical models and drawings will give the lay person a good idea of the human digestive processes. This exhibit will be added to the existing list of displays on the human body, including "You and Your Body," "Your Bones and Your Muscles," "We See," "We Hear," and the ever-popular "Life Begins." The Bureau hopes to have this exhibit available for the 1957 state and county fair season.

INDEX TO ADVERTISERS

Abbott Laboratories ... 136-137, 235
Ames Company, Inc. ... 138
Ann Arbor School ... 234
Appalachian Hall ... 151
Atlas Pharmaceutical Laboratories ... 214
Ayerst Laboratories, Inc. ... 217
Baker Laboratories, Inc. ... 244
Burroughs, Wellcome & Co. (U.S.A.) Inc. ... 231, 239, 246
California State Personnel Board ... 243
Ciba Pharmaceutical Products, Inc. ... 143
Coca-Cola Company ... 248
Columbus Pharmacal Company ... 131
Cook County Graduate School of Medicine ... 238
Corn Products Refining Co. ... 149
Davies, Rose & Co., Ltd. ... 241
Desitin Chemical Company ... 160
Endo Products, Inc. ... 140
Ethicon, Inc. ... 133
Flint, Eaton & Company ... 249
Foot-so-Port Shoe Company ... 224
Geigy Pharmaceuticals, Inc. ... 134
General Electric Company, X-Ray Dept. ... 142
Harding Sanitarium ... 152
Hoffmann-LaRoche, Inc., ... Insert between pages 176 - 177
Knox, Chas. B., Gelatine Co., Inc. ... 247
Lakeside Laboratories, Inc. ... 129
Lederle Laboratories ... 155, 198 - 199
Lewal Pharmaceutical Company ... 240
Liebel-Flarsheim Co. ... 153
Lilly, Eli, and Company ... 164
Lloyd Brothers, Inc. ... 250 - 251
Mallard, Inc. ... 212
Mead Johnson & Company ... 139
Medical Protective Company ... 236
Merck Sharp & Dohme ... 141, 161, 227, 229, 237
New York Polyclinic Medical School ... 248
Parke, Davis & Company ... 156-157; 252 and Inside Back Cover
Pfizer, Chas. & Co., Inc. ... 135, 225, 245
Picker X-Ray Corporation ... 233
Rawl Chemical Company ... 151
Riker Laboratories, Inc. ... 221
Robins, A. H., Co., Inc. ... 224, 232, 236
Sanborn Company ... 215
Sawyer Sanatorium ... 144
Schering Corporation ... Insert Between Pages 152 - 153; Pages 158 - 159, 162 - 163
Scroggins, Clayton L., Associates (Medical-Dental Management) ... 152
Searle, G. D., & Company ... 211
Smith, Kline & French Laboratories ... 147 and Back Cover
Squibb, E. R., & Sons, Division of Olin-Mathieson Chemical Corporation ... 154
Stoneman Press ... 150
Tutag, S. J., & Company ... 150
Wallace Laboratories ... 223
Wendt-Bristol Company ... 234
Windsor Hospital, Inc. ... 216
Winthrop Laboratories ... Insert Between Pages 144 - 145



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MIAMI—Charles M. Oxley, President, Troy; Dale A. Hudson, Secretary, Piqua. 1st Friday, monthly, except July, August.

MONTGOMERY—R. Dean Dooley, President, Dayton; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Building, Dayton. 1st Friday, monthly, except July, August and September.

PREBLE—E. P. Trittschuh, President, Lewisburg; John R. Bowman, Secretary, Eaton. November of each year.

SHELBY—James W. Tirey, President, Anna; Robert H. Lanfersieck, Secretary, Sidney. 1st Tuesday, monthly.

THIRD DISTRICT

ALLEN—David L. Steiner, President, Lima; Thomas D. Allison, Secretary, Lima. 3rd Tuesday, monthly, except June, July and August.

AUGLAIZE—William V. Barton, President, St. Marys; Dale L. Kile, Secretary, St. Marys. No monthly meeting date given.

CRAWFORD—Charles J. Grieblinq, President, Galion; James E. Loggins, Secretary, Galion. 3rd Friday, monthly.

HANCOCK—R. Grant Janes, President, Findlay; Benjamin H. Saunders, Jr., Secretary, Findlay. 3rd Tuesday, monthly.

HARDIN—Richard A. Dietrich, President, LaRue; Wm. F. Binkley, Secretary, Kenton. 2nd Tuesday, monthly.

LOGAN—Charles H. Thompson, President, West Mansfield; Charles A. Browning, Jr., Secretary, Bellefontaine. No monthly meeting date given.

MARION—John T. Boxwell, President, Marion; Thomas N Quilter, Secretary, Marion. 1st Tuesday, monthly.

MERCER—Robert M. Fell, President, Celina; Julius Schwieger, Secretary, Fort Recovery. 3rd Thursday, monthly.

SENECA—Leonard M. Gaydos, President, Tiffin; Robert K Rawers, Secretary, Tiffin. 3rd Tuesday, monthly.

VAN WERT—Edwin Wm. Burnes, President, Van Wert; Norman L. Marxen, Secretary, Van Wert. 1st Friday.

WYANDOT—Talmadge R. Huston, President, Carey; Allen F. Murphy, Secretary, Upper Sandusky. 2nd Tuesday.

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FULTON—Edwin R. Murbach, President, Archbold; Robert A. Ebersole, Secretary, Archbold. 4th Tuesday, monthly.

HENRY—Bernard J. George, President, Liberty Center; Thomas F. Tabler, Secretary, Holgate. 1st Tuesday.

LUCAS—Max T. Schnitker, President, Toledo; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo. 3rd Tuesday, monthly.

OTTAWA—Cyrus R. Wood, President, Port Clinton; F. Kraft Ritter, Secretary, Port Clinton. 2nd Thurs., monthly.

PAULDING—T. P. Fast, President, Grover Hill; John H. Schaefer, Secretary, Paulding. Monthly meeting date: "Not set as yet."

PUTNAM—James B. Overmier, President, Leipsic; Will W. Moody, Secretary, Vaughnsville. 1st Tuesday, except June, July and August.

SANDUSKY—Karl K. Grubaugh, President, Woodville; R. Allen Eyestone, Secretary, Gibsonburg. 3rd Wednesday, monthly, except June, July and August.

WILLIAMS—Robert A. Gilreath, President, Bryan; Robert W. Dilworth, Secretary, Montpelier. 3rd Tues., monthly.

WOOD—J. Victor Pilliod, President, Grand Rapids; Richard L. Pearse, Secretary, Bowling Green. 3rd Thurs., monthly.

FIFTH DISTRICT

ASHTABULA—Harold C. Franley, President, Jefferson; Arthur B. Shaul, Secretary, Ashtabula. 2nd Tuesday.

CUYAHOGA—A. Macon Leigh, President, Cleveland; Mr. M. John Hanni, Jr., Executive Secretary, 2009 Adelbert Road, Cleveland. 2nd Tuesday, monthly.

GEAUGA—Walter C. Corey, President, Chardon; Alton W. Behm, Secretary, Chardon. 2nd Friday, monthly.

LAKE—Anthony J. DiCello, President, Painesville; Howard Stephens, Secretary, Mentor. 2nd Tuesday, monthly.

SIXTH DISTRICT

COLUMBIANA—Robert N. Osmundsen, President, Salem; Richard J. McConnor, Secretary, Salem. 3rd Tues., monthly.

MAHONING—Stephen W. Ondash, President, Youngstown. Mrs. Mary B. Herald, Executive Secretary, 125 Commerce Street, Youngstown. 3rd Tuesday, monthly.

PORTAGE—Robert E. Roy, President, Ravenna; Arthur L. Knight, Secretary, Apco. Tentatively, 3rd Tuesday.

STARK—R. E. Tschantz, President, Canton; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton. 2nd Thursday, monthly.

SUMMIT—Robert G. McCready, President, Akron; Miss Betty Haydon, Office Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly, September through June.

TRUMBULL—Joseph A. Browning, President, Warren; Robert J. Willoughby, Secretary, Warren. 3rd Wed., monthly.

SEVENTH DISTRICT

BELMONT—A. John Antalis, President, Powhatan Point; Bertha M. Joseph, Secretary, Martins Ferry. 3rd Thursday, except July, August.

CARROLL—P. S. Whitecather, President, Minerva; Robert H. Hines, Secretary, Minerva. No monthly meeting date given.

COSHOCTON—John L. Magness, President, Coshocton; Harold W. Lear, Secretary, Coshocton. 2nd Tuesday, monthly.

HARRISON—Carl J. Nicosia, President, Bowerston; Richard W. Weiser, Secretary, Jewett. Meetings: March, June, September, December.

JEFFERSON—Warren G. Snyder, President, Wintersville; Frances J. Shaffer, Secretary, Toronto. 2nd Tuesday.

MONROE—Byron Gillespie, President, Woodsfield; Albert R. Burkhart, Secretary, Woodsfield. "No Meetings."

TUSCARAWAS—Paul D. Hahn, President, New Philadelphia; Arthur J. Stevenson, Secretary, New Philadelphia. 2nd Thursday, monthly.

EIGHTH DISTRICT

ATHENS—John P. Greenlees, President, Glouster; Charles R. Hoskins, Secretary, Athens. 2nd Tuesday, monthly.

FAIRFIELD—George F. Jones, President, Lancaster; Arthur B. VanGundy, Secretary, Lancaster. 2nd Tuesday, monthly.

GUERNSEY—John Wm. Camp, President, Cambridge; Albert C. Smith, Jr., Secretary, Cambridge. 1st Thurs., monthly.

LICKING—Clarence G. Faue, President, Newark; Paul N. Montalto, Secretary, Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, McConnelsville. Called Meetings.

MUSKINGUM—William B. Faircloth, President, Zanesville; William A. Knapp, Secretary, Zanesville. 1st Tuesday.

NOBLE—Norman S. Reed, President, Caldwell; Edward G. Ditch, Secretary, Caldwell. 2nd Tuesday, monthly.

PERRY—C. B. McDougal, President, New Lexington; O. D. Ball, Secretary, New Lexington. Called meetings.

WASHINGTON—James T. Asch, President, Marietta; Joseph E. LaBarre, Secretary, Marietta. 2nd Wednes., monthly.

NINTH DISTRICT

GALLIA—John C. Markley, President, Gallipolis; Robert P. Carson, Secretary, Gallipolis. Last Thursday, monthly.

HOCKING—Howard M. Boocks, President, Logan; Richard C. Jones, Secretary, Logan. No meeting date given.

JACKSON—Alvis R. Hambrick, President, Wellston; Brinton J. Allison, Secretary, Oak Hill. Called Meetings.

LAWRENCE—Harry Nenni, President, Ironton; George Newton Spears, Secretary, Ironton. 2nd Tuesday, monthly.

MEIGS—Joseph J. Davis, President, Middleport; Charles J. Mullen, Secretary, Pomeroy. No meeting date given.

PIKE—Cecil L. Grumbles, President, Waverly; Benton V. D. Scott, Secretary, Waverly. 1st Tuesday, monthly.

SCIOTO—Joseph T. Gohmann, President, Portsmouth; Carl H. Laestar, Secretary, Portsmouth. 2nd Monday, monthly.

VINTON—Richard E. Bullock, President, McArthur; H. D. Chamberlain, Secretary, McArthur. None.

TENTH DISTRICT

DELAWARE—Emerson V. Arnold, President, Delaware; F. M. Stratton, Secretary, Delaware. 3rd Tuesday, monthly.

FAYETTE—Frank C. King, President, Washington C. H.; H. Wm. Payton, Secretary, Jeffersonville. 2nd Tuesday.

FRANKLIN—Norman O. Rothermich, President, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus 15. Monthly meeting dates discontinued; Will meet in January, March, June and October.

KNOX—James C. McLarnan, President, Mt. Vernon; Clinton W. Trott, Secretary, Mt. Vernon. 1st Thursday.

MADISON—Ernest S. Crouch, President, London; Robert S. Postle, Secretary, London. 1st Wednesday, monthly.

MORROW—Joseph P. Ingmire, President, Mt. Gilead; Lowell Murphy, Secretary, Cardington. 1st Tuesday, monthly.

PICKAWAY—Ray Carroll, President, Circleville; E. L. Montgomery, Secretary, Circleville. 1st Friday, monthly.

ROSS—Charles N. Hoyt, President, Chillicothe; Robert E. Quinn, Secretary, Chillicothe. 1st Thursday, monthly.

UNION—Paul Richard Zaugg, President, Marysville; May B. Zaugg, Secretary, Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—Charles H. McMullen, President, Loudonville; William H. Rower, Secretary, Ashland. 1st Friday, monthly.

ERIE—Herbert F. Kesinger, President, Sandusky; S. R. Hoover, Secretary, Sandusky. 4th Thursday, monthly.

HOLMES—Luther W. High, President, Millersburg; Owen F. Patterson, Secretary, Millersburg. 2nd Wednesday.

HURON—William W. Corwin, President, Willard; John V. Emery, Secretary, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—James T. Stephens, President, Oberlin; Conrad T. Rusin, Secretary, Lorain. 2nd Tuesday, monthly.

MEDINA—Christian F. Schrier, President, Litchfield; Robert E. Smith, Secretary, Medina. 3rd Thursday, monthly.

RICHLAND—Harry Wain, President, Mansfield; Riley E. Frush, Secretary, Mansfield. 3rd Thursday, monthly.

WAYNE—Ehert E. Judd, President, Wooster; Charles H. Brant, Secretary, Wooster. 2nd Wednesday, monthly.

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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

The Flavonoids in Biology and Medicine: A Critical Review, by M. E. Shils, Sc. D., and R. S. Goodhart, M. D. ($2.00. *The National Vitamin Foundation Inc., New York 22, N. Y.)* This is a critical review of the experimental literature leading to the conclusion that there is no valid experimental evidence that these substances play a nutritional role. Furthermore a critical review of the clinical literature also leads to the conclusion that burden of proof is still on those who claim therapeutic value to the substance. A bibliography of 299 references is appended.

Shock and Circulatory Homeostasis, Transactions of the Fourth Conference, edited by Harold Green, M. D. ($5.00. *Josiah Macy Jr. Foundation, Packanack Lake, N. J.)* In this conference the action of Epinephrine in Man; the Circulation in the Periphery, Mesenteric Lymphatic Dynamics; The Circulation in the Splanchnic Area; the Pulmonary Circulation; The Pulmonary Circulation in Hemorrhagic Shock, and The Aortic and Coronary Blood Flow were the topics considered.

Man's High Adventure, by Samuel A. Harper with an introduction by Anton J. Carlson. ($3.00. *Ralph Fletcher Seymour, Publisher, 410 S. Michigan Ave., Chicago, Ill.)* "To become aware of the infinite cosmos, the relation of his small planet thereto, his common origin and kinship with everything that shines and lives, his participation in the creative processes of evolution; and to direct the great forces of Nature, of himself and of his society to the ultimate, supreme good of the human race—this is Man's High Adventure."

Carlson says, "I think that most adult, informed and rational citizens will see eye to eye with Mr. Harper in his final conclusion that scientific humanism is a higher adventure for man than any traditional or revealed guesses as to man's nature and destiny."

District Nursing, by Eleanor Jeanette Merry and Iris Dundas Irven. ($4.50. 2nd ed. *Baillaire, Tindall and Cox, London, England;* United States distributor: *Williams and Wilkins Co., Baltimore 2, Md.)* This is a handbook for district nurses and for all who are concerned in the administrative duties of a district nursing service. In this edition is included a considerable amount of material relating to the National Health Service Act. Yet the information for organizations on a voluntary basis have been retained.

Pathologic Physiology, edited by William A. Sodeman, M. D. ($13.00. 2nd ed. *W. B. Saunders Co., Philadelphia 5, Pa.)* With revision and rewriting this important text has been brought up to date. There is a new chapter on Genetics, Growth, and Neoplasia by Madge T. Macklin of Ohio State University. This edition will certainly get as warm a reception as did the first from physicians who wish to keep their thinking about disease dynamic.

Electrocardiography: Fundamentals and Clinical Application, by Louis Wolff, M. D. ($7.00. 2nd edition. *W. B. Saunders Co., Philadelphia 5, Pa.)* The author has continued his policy of making his text serve the busy clinician. "Completeness as sacrificed for conciseness and clarity and only that presented which from the author's personal experience has proved useful." There is a new section on the arrhythmias.

The Natural Childbirth Primer, by Grantly Dick Read, M. D. ($1.50. *Harper & Brothers, New York, N. Y.)* This is a detailed and well illustrated manual of the Childbirth Without Fear System of the author—well known throughout the world. It always seemed best to mere man that babies be born rather than delivered.

Your Blood Pressure and How to Live With It, by William A. Brams, M.D. ($2.95. *J. B. Lippincott Co., Philadelphia, Pa.)* The author of the award-winning **Managing Your Coronary** gives here a hopeful bit of advice in an attempt to dispel fear and unwarranted anxiety among patients with high blood pressure.

Thoracic Surgical Management, by J. R. Belcher and I. W. B. Grant. ($4.75. 2nd ed. *Baillaire, Tindall and Cox, London, England,* United States distributor, *William & Wilkins Co., Baltimore 2, Maryland.)* A clearly written book on the assumption that the reader knows but little about the subject. Excellent therefore for the resident staff and nurses.

The Yearbook of Modern Nursing: 1956, edited by M. Cordelia Cowan, Foreword by Mary M. Roberts. ($4.95. *G. P. Putnam's Sons, New York 16, N. Y.)* For the first time, nursing is to have a yearbook. The book is made possible through the combined efforts of 154 nurses, educators and specialists. The content is made up of some 450 pages of original writings as well as digests, annotated bibliographies prepared by the contributors after searching both published and unpublished sources to select from the areas of nursing, education, science, health, hospital administration and related fields.

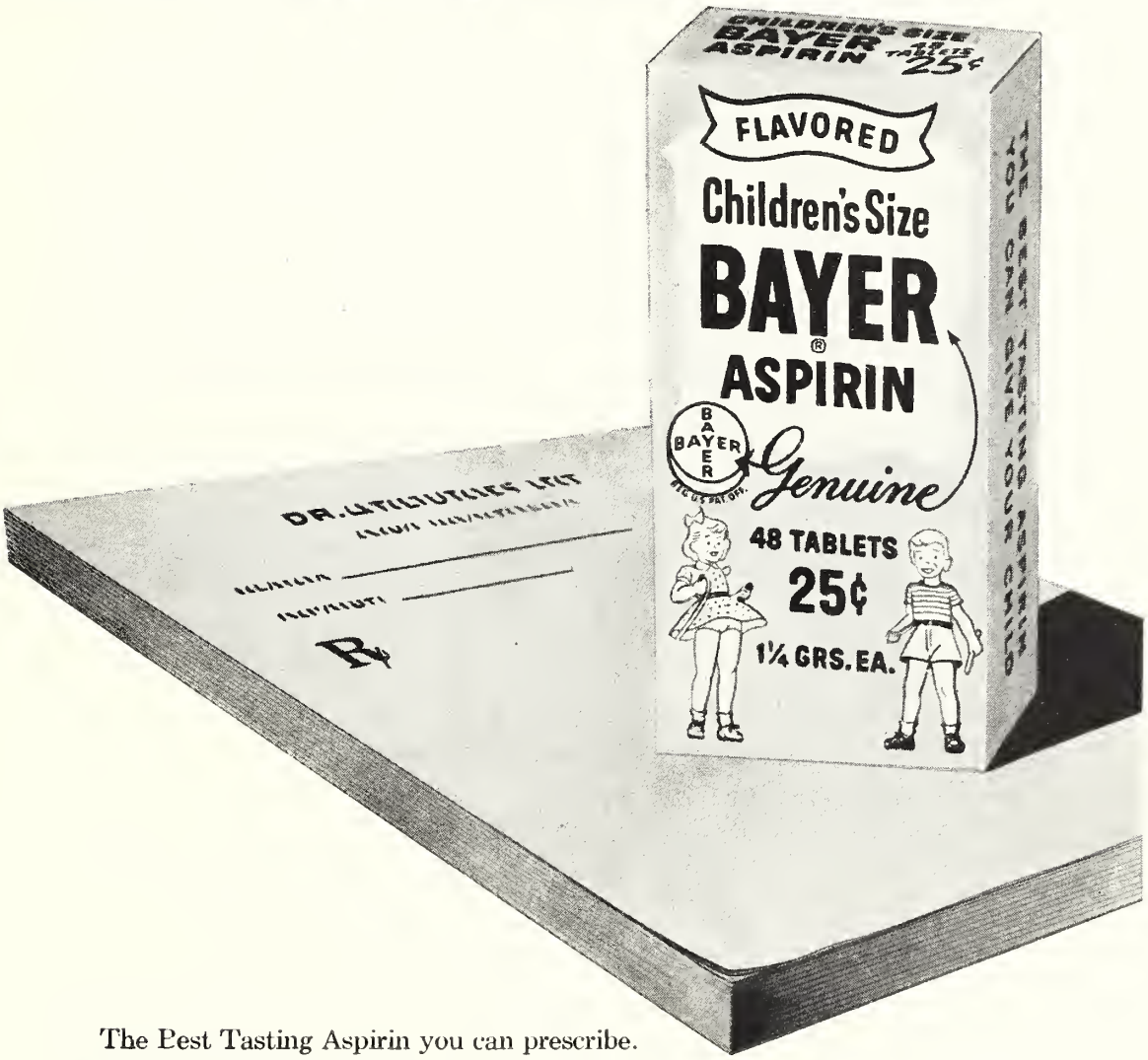
Hunterdon Medical Center, by Ray E. Trussell, M. D. ($3.75. *A Commonwealth Fund Book, Harvard University Press, Cambridge, Mass.)* The 40,000 people of Hunterdon County, New Jersey, after a study of the county's needs for medical

(Continued on Page 268)



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care developed a medical center with a county-wide program embracing many noteworthy features. Here is the story of the movement from its inception in 1946. It is to be noted that here is another apparently successful attempt for socialization of the profession. The salaried, full-time staff of specialists also hold University appointments and the Center is affiliated with Bellvue. General practitioners of the county share the responsibility for their patients with the appropriate staff specialist.

Cancer of the Lung: Pathology, Diagnosis and Treatment, by Milton B. Rosenblatt, M. D., and James R. Lisa, M. D., with eight contributors. ($15.00. *Oxford University Press, New York, New York.)* At once the most comprehensive as well as the most authoritative work devoted to all aspects of bronchogenic carcinoma, this important treatise will render valuable service to both the specialist and to the general practitioner.

Obstetrical Anesthesia, by Bert B. Hershenson, M. D. ($9.50, *C. C. Thomas, Springfield, Ill.)* The purpose of this book is to present useful information to the physician who may be called upon to manage all of the complications of anesthesia at the time of a delivery. The principles of clinical physiology and clinical pharmacology are stressed. It certainly belongs in every intern library.

Better Health Through Better Living, by the Fellows of the New York Academy of Medicine. ($3.00. *The Dial Press, New York, N. Y.)* A group of distinguished physicians—each an expert on his topic presents the fundamentals of good health for layman.

A Method of Balanced Anesthesia, in General Surgery, Obstetrics, and Dentistry, by Sylvan M. Shane, D. D. S., and Harry Ashman, M. D. ($2.25. *Lowry and Volz, Baltimore, Md.)* This book presents the authors' methods and reports the results in over 20,000 administrations to humans. The method employs no ether but does use a mixture of gases including cyclopropane administered in either a semi-closed or non-rebreathing system —*never* in a closed rebreathing system.

In the Doctor's Office, by Esther Jane Parsons. ($3.95. 2nd ed. *J. B. Lippincott Co., Philadelphia 5, Pa.)* The author, a former assistant and a teacher of assistants, presents out of her experiences concise yet complete guides for the medical assistant.

Laboratory Tests in Common Use, by Solomon Garb, M. D. ($2.00. *Springer Publication Co., New York 10, N. Y.)* The author devotes 122 pages to "tests according to type of specimen employed, 10 pages to tests according to the anatomical system being studied and 2 pages to units of measurements." An excellent little manual for the nurse or office assistant.

Fibrocystic Disease of the Pancreas, A Report of the 18th Ross Pediatric Research Conference. (Apply, *Ross Laboratories, Columbus 16, Ohio.)* A large group of pediatricians and investigators contribute to the proceedings of this conference.

Medical Trial Technique Quarterly, edited by Irving Goldstein, LL. B., and Nathan Flaxman, M. D. ($15.00 per annum. *Callaghan & Company, Chicago 30, Ill.)* Issued four times a year, this is a medicolegal publication designed to meet the special problems that are met in the field of personal litigation. At the end of the year all material of lasting interest is consolidated, indexed and bound in book form.

The Zoonoses in Their Relation to Rural Health, by Karl F. Meyer. ($1.00. *University of California Press, Berkeley or Los Angeles, Calif.)* The word "zoonoses" was coined by Virchow, is applied to infections of animals that secondarily are contagious to man and this book covers well the public health aspects as it applies to rural people.

Crusading Doctor, by Michael A. Shadid. ($3.00. *Meador Publ. Co., Boston, Mass.)* The autobiography of the founder of the Elk City Oklahoma Medical Cooperative.

Magic, Myth and Medicine, by D. T. Atkinson, M. D. ($5.00. *The World Publishing Co., Cleveland, Ohio.)* An unusual type of medical history telling the story of the advances in the healing art from its beginning in magic to the victories of modern medicine. It is told in terms of men who died thinking they had failed, of hard work and perseverance.

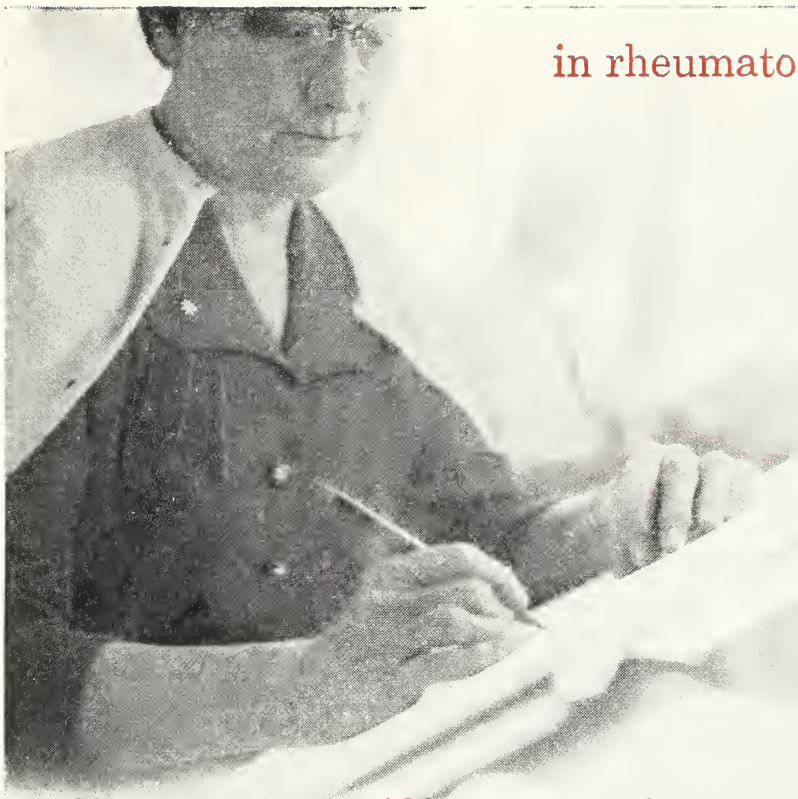
The Microbe's Contribution to Biology, by A. J. Kluyver and C. B. van Niel. ($4.00. *Harvard University Press, Cambridge 38, Mass.)* This book presents the John M. Prather Lectures: 1954. Natural scientists are often unaware of the contributions which studies with micro-organisms have made to the broader concepts covering the whole field of biology. These lectures cover all the contributions.

Planning Florida's Health Leadership, edited by Louis J. Maloof. ($1.50. *University of Florida Press, Gainesville, Florida.)* This is the fifth volume in this series dealing with those departments of instruction and other programs of the University which are related to Medical Education and Medical Research and which would lend themselves to integration. This study was sponsored by the Commonwealth Fund.

Essentials for Writing, by J. K. Lowers, V. T. Furman and M. E. C. Kibbey, ($1.75. Revised Edition. *American Book Company, New York 3, New York)*, is a practical text seeking to develop a critical attitude toward one's written work.

Cancer Through the Ages: The Evolution of Hope, by Francelia Butler. ($1.00. *Virginia Press, Fairfax, Va.)* To evaluate a problem, it is often

(Continued on Page 270)

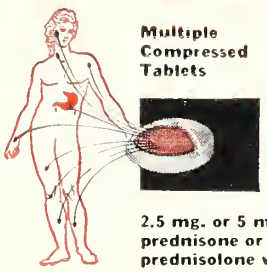


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References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* 158:459 (June 11) 1955.

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Collagen Disease, by John H. Talbott, M. D., and R. Moleres Ferrandis. ($6.50. *Grune and Stratton Inc., New York, N. Y.)* This is a nicely illustrated report on current concepts about Systemic Lupus Erythematosus, Polyarteritis, Dermatomyositis, Systemic Scleroderma, and Thrombotic Thrombocytic Purpura.

The Mighty Force of Research, by the Editors of *Fortune*. ($4.00. *McGraw Hill Book Co., New York 36, N. Y.)* Reprint of a series of fascinating stories of how research and the men behind it in America today are producing new scientific discoveries in water, weather, the human brain, chemicals for agriculture, power from the sun, metals, peacetime atomic energy, electronics automation and many other fields.

Cancer and Allied Diseases, by Ronald W. Raven, F.R.C.S. ($2.25. *Regnery Company, 20 W. Jackson Blvd., Chicago, Ill.)* This book in Regnery's Modern Health Series is designed to educate and to raise the reader's index of suspicion without creating hysterical fear of cancer.

Diabetes, by G. F. Walker, M. D. ($2.25. Modern Health Series. *Regnery Company, 20 W. Jackson Blvd., Chicago, Ill.)* A British authority tells the layman what he should know about the disease in order that he may cooperate with his physician.

Facts of Life for Children, edited by Adie Suehsdorf, by the Child Study Association of America. ($.50. *Maco Books, New York 17, N. Y.)* Gives the official answers for us to give when our child of six asks about sex.

Discover Yourself; A Practical Guide to Autoanalysis, by Dr. Steven Lackner. ($2.95. *Merlin Press Inc., New York 19, N. Y.)* This is a psychoanalysis which uses the discovery of the pioneer analysists but in a dogmatic way. It also uses "mental tools" of autosuggestive nature, as well as symbolic objects, to make the mental efforts concrete and effective.

Visiting Nurse, by Margaret Howe. ($2.50. *Avalon Books, New York 22, N. Y.)* It is a novel based upon the attempts of a nurse to bring a sullen and resentful, beautiful and attractive patient back to the awareness of life.

Clinical Chemistry, by Joseph S. Annino, ($7.50. *Little Brown & Co., Boston 6, Mass.)* The clinical chemist of the Massachusetts Memorial Hospital of Boston presents the principles and procedures in the modern chemical hospital laboratory.

A New Approach to Schizophrenia, by Julius I. Steinfeld, M. D. ($4.95. *Merlin Press, Inc., New York 19, N. Y.)* This is the author's opus magnum and unfortunately his last. He died shortly after he read the proof. He points out that in the history of the majority of these patients there is an early alimentary disturbance. In this "hunger

(Continued on Page 272)



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Medicinal Chemistry Vol. II, edited by F. F. Blicke and C. M. Suter. ($10.00. *John Wiley and Sons, Inc., New York 16, N. Y.)* This is one of a series of reviews prepared under the auspices of the American Chemical Society. It deals with Cardiac Glycosides, Synthetic Estrogens, Analgesics and Adrenergic blocking agents.

Their Mothers' Daughters, by Edward A. Strecker, M. D., and Vincent T. Lathbury, M. D. ($3.75. *J. B. Lippincott Co., Philadelphia 5, Pa.)* This is a companion volume to **Their Mothers' Sons.** These two eminent psychiatrists lay bare the devasting influence of mothers on the lives of their children.

Enjoying Health, by Evelyn G. Jones, ($3.40. 2nd ed. *J. B. Lippincott Co., Philadelphia 5, Pa.)* It is a successful text based on the findings of the Denver study of health interest of children. It serves as an excellent guide in an attempt to modify their health behavior.

Fluid Balance, Handbook for Practitioners, by William Snively, Jr., M. D., and M. J. Sweeney, M. D. ($6.75. *Charles C. Thomas Publisher, Springfield, Ill.)* It is a working manual based upon years of experience in teaching and practice.

Proctology, by Harry Bacon, M. D., S. T. Ross, M. D., and P. M. Recio, M. D. ($10.00. *J. B. Lippincott Co., Philadelphia 5, Pa.)* This book is designed in particular for the general man. It offers the essential facts of the colon, rectum and anal canal.

Textbook of British Surgery, Vol. I: Abdomen, edited by Sir Henry Souttar, M. D. ($24.75. *Essential Books Inc., Fair Lawn, N. J.)* This is the first of three volumes complete in itself. It aims to be a complete account of the present position in the field of abdominal surgery as seen by the experts to whom each section has been entrusted.

Clinical Urology for General Practice, by J. J. Cordonnier, M. D. ($6.75. *C. V. Mosby Co., St. Louis 3, Mo.)* This is a text designed to supply essential knowledge in a concise form and it is based upon the material used to teach senior students at Washington University.

Basic Otolaryngology, by Francis L. Lederer, M. D., and A. R. Hollender, M. D. ($6.75. Fourth edition. *F. A. Davis Co., Philadelphia 3, Pa.)* A textbook according to established standards which has justified itself in previous editions. The book has been reduced in size by a formulated plan.

The Nature of Hypnosis, by Paul Schilder, translated by Greda Corvin. ($4.00. *International Universities Press Inc., New York, N. Y.)* The original German monograph goes back to 1921. This is essentially a re-issue of a book long out of print.

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Psychological Aspects of Rehabilitation

ALEXANDER P. ORFIRER, M.D.

THERE are psychological reactions to most of the events which impinge on the human organism. Events, which might have great importance to some may seem of not much importance to others. But the event of ill health, especially when it is prolonged and leaves a disability behind, always arouses psychological reactions of various kinds. These reactions may be more or less apparent but they are always present. When we speak of psychological reactions, we are usually concerned with those we consider pathological in some degree. But it is sometimes difficult to delineate between the pathological and the normal.

MUST EXPECT PSYCHOLOGICAL REACTIONS

It is considered abnormal for the individual not to show certain psychological reactions after the trauma to the central nervous system which results in the hemiplegia. In other words, the trauma results in psychological as well as anatomic and physiological changes in the organism.

With the onset of the hemiplegia, a profound change takes place in the individual. Until now he has been an independent person who was able to look after his own needs, find his own sources of satisfaction, and do something about those things or events in his life which caused him an unpleasant tension. Any problems he might have around self-esteem had been kept in some kind of balance by his obvious physical and mental abilities. He could do things which he and those around him could see and respect him for. He has a job, has raised a family—all of which is evidence that he can be a man in the way that society demands of a "grown-up" person.

With the onset of the hemiplegia, the patient not only loses the ability to meet his own needs but also has to contend with his feelings about that. He suddenly is no longer able to maintain his independence and is thrown into the position of being as dependent upon others as he had been at only one other period of his life—during his childhood.

There are many reactions to all of this and we will try to discuss a few.

REACTION OF ANXIETY

The first reaction we see in the patient is one of great anxiety and the feeling that everything is out of control. That suddenly parts of his body are no longer available to him and that many functions are lost to him. This arouses a panic and he turns to others for help. In this plight, he turns to his doctor as the person who will get things back under control. To the doctor he turns as a child turns to his parents—as the person who will in some magical way make everything all right, again. In his efforts to get things under control, the patient also makes use

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of certain protective measures, ones that have helped before. For example, in all of his past experience with disease, one thing was always considered helpful and that was to retire to the comfort and security of his bed.

FIRST STEP IN REHABILITATION

The bed becomes very quickly a place of safety for him and it is in this initial period that the doctor must take the first step toward rehabilitation. Here the physician makes use of the dependence of the patient on him and shows him, not only by his explanation, but also by the assurance of his support and his air of having things under control, that everything will be under control even if he gives up his bed—his place of safety. The patient can do this only if something is given him to replace it.

At that moment, we cannot give him any medication which will return his function. He must get out of bed with almost as much disability as he went into it—but we give him instead a feeling that we expect things of him in return for which he has all the strength which we represent at his disposal. There are many parallels to this in daily living—we give up the safety of firm ground to the dangers of water on the condition that the powerful parent or instructor lends us his support and encouragement when we need it.

The psychological basis of rehabilitation lies in this relationship. It is in the patient's reaction to this dependence and the physician's skill and management of it that the success or failure of the process depends. In no other field of medical endeavor is this interaction between physician and patient of greater importance.

MEANING OF DEPENDENCE

A second group of reactions, which we must take into account, are those toward the real dependency in which the patient finds himself because of his illness. The ideal reaction is one of recognition of the need to be dependent on others as a necessary phase toward future independence, but many of our patients cannot reach this attitude easily. For some of them being dependent carries the meaning of being helpless and at the mercy of hostile forces. They feel themselves in a vulnerable position in which they cannot defend themselves against all the strange things that may be done to them. These are the patients to whom it is so important to explain carefully, exactly what will be done, and for whom there should be no surprises.

For others, being dependent is not allowed. These are the patients who cannot permit others to help them, as though an adult should do everything for himself, regardless of circumstances. Unfortunately, this can be a great interference in keeping the patient from doing the things he can learn to do with help, while he spends much energy on the things he can't yet accomplish. These patients must be shown, patiently and in many ways, that they are not thought any less of because they can't do everything; that their dependence is justified by their illness, that it is their right and not something which has to be fought for. With such a patient one cannot wait for him to indicate his needs because he won't do it. They have to be anticipated and planned for him. Some patients fear that if they did not enlarge and impress others with their plight, this care and attention would be removed and they would be left helpless and alone.

REACTION TO LOSS

Another reaction that we always see in the patient is a reaction to the loss. The hemiplegia represents a monumental loss of many things. The loss of a function can mean the same as an amputation of the limb itself. The recognition of the loss brings with it grief and anger. This is to be expected. If we think of our own reaction when we have lost an object, or a person who has been precious to us, we can understand the patient's reaction. The patient, in effect, goes through a certain period of mourning in which he gradually accepts and adjusts to the loss. This is a necessary phase in his future adjustment. It is a period which family and friends find hard to understand. They will mistakenly try, very hard, to cheer up the patient by jollying him, by trying to minimize the importance of his loss with the paradoxical result that he becomes more depressed than he was before. This does not imply that everyone should sit around glumly with a long face, but rather with an attitude of respect for the patient's feeling about his loss and a determination to do everything possible to help him overcome the effects of it.

Mixed in with the grief is very often a greater or lesser degree of aggression or anger. Again, it is helpful if we think of our own reaction if we are arbitrarily deprived of something precious. Let us say that someone comes along and steals our car. We react to this with great anger but we are then better off than is our patient. We have somebody on whom we can focus our anger. The patient, who also feels as though he has been arbitrarily deprived of something even more precious, has no one on whom he can focus the anger which he feels. He may show it in many ways, with a great irritability and sensitivity about all sorts of things, with an unexplainable anger toward those closest to him and toward the doctor, who is the one closest to him and to his disease. Here a vicious circle can become established in which the patient's anger is met with the anger of those around him. This increases his anger and so it goes.

Here, the physician's psychological understanding can play a most important role. Knowing what the patient must be feeling, he can help the patient to express these feelings in words and

can show him that even if there is no one at fault against whom he can direct his anger, he can still feel angry—and that such anger is understandable and acceptable. The physician will make this expression possible by his interest in not only the disease process itself but in the patient's reactions. An important psychological principle is involved in this. As human beings we have only two ways to get rid of our feelings—one is by words and the other by actions. It is the actions not the words which will interfere with our rehabilitative task. If we can help the patient to express these feelings of anger to us in words, it also has the effect of increasing his trust in us and serves to increase the amount of energy available for the long road ahead.

REACTION OF DENIAL

Another reaction of tremendous importance is a very common one which is best described by the term, denial. This is on the surface a very inexplicable thing because the patient reacts completely, or in some degree, in a very strange way. He acts as though, or tries to act as though, the illness or injury does not exist. He may do this in many ways. He may deny completely that the illness or its symptoms are present at all. More commonly, he may accept the fact that there is an illness but insist that it is really of no importance, that it will take care of itself and that no treatment is necessary; or, and this is even more frequent, he may intellectually accept the fact of the illness and its treatment but act out his denial; that is, act in such a way that his behavior is more appropriate to an attitude of denial than to the acceptance which he consciously displays.

EXAMPLE OF DENIAL

A good example of this was a man I knew in one hospital. He was a man in his middle fifties, who suffered a cerebrovascular accident while on a business trip. He was left with a right hemiplegia, after a stormy initial phase of his illness. After this initial period, he was sent back home to a hospital for his rehabilitation. The notes sent with him were full of comments on his cheerful attitude and his amazing acceptance of his illness.

He was considered an excellent candidate for rehabilitation and a program was set up for him that had every promise of success. After a period of time, the patient had not only made no progress, but was beginning to show the complications noted so often with the untreated hemiplegia. His attitude was everything one could ask for, on the surface. However, on discussing his course with nurses and physical therapists, it was noted that even though he seemed to understand everything, he acted as though the whole thing was really not very important and seemed to show no more than a perfunctory interest in any activity that had to do with his affected side—particularly the arm which was most involved. Discussions with him had no result—he understood everything and agreed with everything, but then went on with his cheerful unawareness of the rehabilitative program. At first, he was the pet of the physical therapy department where he would crack jokes, cheer up other patients, etc., and as frequently said, "You'd think he was one of the staff rather than one of the patients."

WORK WITH PATIENT

The situation became one of serious concern to everyone and after discussion, it was decided that with the help of the psychiatrist, one of the other physicians who had a good relationship with the patient, would work more closely with him. Over a period of time, it became clear that the denial of his illness was this patient's way of coping with the anxiety which threatened to overwhelm him if he seriously accepted the fact of his illness. The patient gradually brought out the meaning of this illness for him. He had the conviction, hitherto unexpressed, that this was the beginning of an inexorable disease in which he would in a year or two lose the use of all his limbs and then, die. He brought out much feeling about this but it wasn't clear where this conviction had arisen. He was able, finally, to tell the doctor about his father, who had a stroke when the patient was about 10 or 15 years old. At that time, the father was discovered to have diabetes and shortly thereafter developed a gangrene of his unaffected leg and died, following an amputation.

Over a period of time as this patient was helped to bring out his tremendous anxiety, a change took place in his attitude. The denial was no longer as necessary to him. When the anxiety was brought to the view of the patient and the doctor, then it was possible for the doctor to give him the reassurance which the facts of his illness and disability allowed. Then, for the first time, he could really hear what the doctor had to say.

This situation illustrates how important is an attitude toward the patient which permits him to express his anxieties, and that will treat them as an opportunity to explain or patiently re-explain the facts which he must face.

The case also illustrates another point. The doctor who expects his hemiplegic to be up walking without help in two weeks after the stroke, is doomed to bitter disappointment. The doctor who expects that the psychological impact of the stroke can be disposed of in two weeks, is equally doomed to bitter disappointment. The work with the feelings of the patient will last just as long as the rehabilitative job goes on. With this patient, it was a period of months over which the patient gradually brought out his feelings, expressed his fears. Meanwhile, his trust in his doctor increased. At the same time, he could let

himself know more about the facts of his illness. Over this same period, he worked more and more effectively in physical therapy and other activities. All of these were parallel efforts and all part of the same process.

REACTION OF GUILT

Another reaction, underlying various psychological pictures encountered in rehabilitation, is the reaction of guilt. It is the feeling or thought which usually involves the words, "If only I hadn't done that, this wouldn't have happened." This, of course, is a very common reaction and not only confined to the situation in which we are at the moment interested. It has its roots early in our lives and gives us a sense of realistic as well as unrealistic responsibility. I remember one patient, who described his family's reaction to every bad thing that happened to him as one of responsibility, that it must have been his fault and he deserved it. It didn't matter whether he had cut his finger, got into a quarrel, or caught the measles. The child doesn't need this reproach to have exactly the same thoughts, but such reactions on the part of the people around, increase the intensity of these feelings.

UNREAL SENSE OF RESPONSIBILITY

The child, all on his own, never takes it for granted that anything can happen all by itself. He has been warned often enough, that if he had not done such and such a naughty thing, something else would not have happened. And, since every child has a store of undetected, forbidden things he has done, it doesn't seem at all inconceivable to him that measles would be a punishment for those misdeeds, rather than simply a contagious disease just as likely to come without regard to his good or bad behavior.

It is the parents' job to help the child discriminate between those things that are the results of his behavior and those things over which he can have no control, regardless of his behavior. There is a tremendous difference in later years between the child who is allowed to feel he is to blame and the child whose parents can accept the illness in a calming and reassuring way and can say to the child, "It's too bad you're sick; it wasn't your fault, and we'll help you get over it." The doctor, to whom in adult life the patient turns, must help the patient make this discrimination.

Out of guilt, the patient may react with a hopelessness and an inability to do anything. Also, out of guilt, the patient may work in the rehabilitative program as through he were possessed by a demon. We had, at the Cleveland Rehabilitation Center, a young woman with a hemiplegia, following a tuberculous meningitis. Certain exercises were prescribed for her hand and she took to them with great energy. We discovered, after a few weeks, that where we had prescribed a dozen repetitions of a certain maneuver, she would perform several hundred or even a thousand.

She was on a comprehensive program planning for her working within the limits of her disability. She would neglect everything for the sake of her exercises. When she got through a heavy day at the center, she would go home to continue these exercises there. At home her elder brother and parents would continually remind her that if she worked hard enough, she would be all well. And, if she weren't all well, that was a proof she wasn't working hard enough. So, she worked harder.

It was a tremendous job to keep this girl from exhausting herself. She did very well up to the limit set by an irreversible process. Planning with her for anything, short of complete recovery, was impossible. It took many months of patient work to reach the point of being able to help her accept and face the real limitations of her disease. It was as though she had to go through a certain amount of punishment before her guilt would allow her to rest. Without help, she might have spent a lifetime, rather than only a few months, in this process.

CONCLUSION

This discussion can hardly be considered an exhaustive survey of the psychological reactions of patients in the rehabilitative setting. Nor, is it in any way an exhaustive discussion of the reactions which we have mentioned. It can only be presented to you in the sense of an extension of your differential diagnosis. In many of these situations, the diagnosis often made is stubbornness, uncooperativeness, et cetera. As physicians, our life-long task is this extension of, and sharpening of, our differential diagnosis. As we know more of possible reactions of the patient both physiologically and psychologically, then do we stand a better chance of being of help to them.

All of these reactions can be seen to some extent in each of our patients. We must note them and act in such a way as to minimize their effect. We do this so that they do not become accentuated to the point of concern to us.

When these reactions do concern us then we must treat them according to the pattern laid down for us by our medical training. That is, we must treat them as a symptom. When a patient presents us with a symptom, let us say a fever, which we do not understand, we conduct a careful study. We take a careful history and we make a careful examination of the present situation. This is sometimes a difficult task and it may require specialized skills to accomplish such studies. In the larger rehabilitation centers this is accomplished by the efforts of a team of workers. But, I think the general physician, by an awareness of these reactions can be of greater service to his patients in the many rehabilitative tasks in which he is involved.

Metisteroid Therapy of Poison Ivy Dermatitis

LEON GOLDMAN, M. D., and ROBERT PRESTON, M. D.

IN 1953, we reported a two year study of corticosteroids in the therapy of the common dermatitis caused by contact with Rhus radicans.[1] Since that time, there have been a number of pertinent questions concerning the use of these powerful medications in the treatment regimens of dermatitis from poison ivy and poison oak.

1. Is corticosteroid therapy really indicated for such a self-limited dermatitis?
2. If there be indications for such therapy, what is the usual dosage and usual duration of therapy?
3. Should corticosteroid therapy be used in the presence of secondary infection?
4. What is the true value of topical corticosteroid therapy for such dermatitis?
5. What is the effect of corticosteroid therapy on the immune reactions of the patient to subsequent contacts with the antigen complex of Rhus radicans?

CLINICAL FEATURES IN RELATION TO CORTICOSTEROID THERAPY

As we have indicated previously, no critical evaluation of the effect of any therapy for such a circumscribed dermatitis can be made unless two important clinical factors are considered: (1) the severity (mild, moderate, severe); (2) the time relationship of the institution of therapy to the onset of the dermatitis. In brief, we still believe that adequate oral corticosteroid therapy is indicated for the severe case, and often for the moderate case.

Patients can be very ill with poison ivy. In addition to extensive bullous lesions, there may be hemorrhagic types; the patient can be very miserable. Such individuals may require extensive skin nursing care, and be unable to work. Even a mild dermatitis may be irritated by the use of proprietary medications, and become severe. Secondary infection may develop, and, if extensive, may lead to acute nephritis. There may be also such uncommon chronic complications as a persistent localized neurodermatitis from repeated scratchings and rubbings, and, in a patient with active or latent psoriasis, some or even all lesions may become psoriatic. All these complications we have observed.

Adequate corticosteroid therapy can shorten the course of poison ivy or poison dermatitis and make the patient more comfortable. For such brief courses in individuals who are otherwise healthy, complications of use of the corticosteroids are uncommon.

DOSAGE SCHEDULE

For corticosteroid therapy to be effective in such a severe vesiculobullous eruption, the dosage must be adequate. We now give initial doses larger than we gave previously. For the past two years, we have used oral metisteroids instead of hydrocortisone in a series of over 300 patients varying in age from 2 years to 77 years. We believe that, at present, oral metisteroids are the steroids of choice for poison ivy dermatitis. We have observed no differences in dosage for prednisone vs. prednisolone. The average dosage for the adult patient with a severe poison ivy dermatitis is:

1st day—25 to 30 mg.	4th day—20 mg.
2nd day —30 mg.	5th day—15 mg.
3rd day—20 to 25 mg.	6th day—5 mg.
7th day—2.5 mg.	

The dosage schedule may be individualized. We prefer to discontinue therapy after five to seven days unless the severity of the dermatitis warrants continuation. The usual restrictions regarding any form of oral corticosteroid therapy should be followed. In our series of these relatively brief courses in over 300 patients, we have observed only insomnia, fatigue in three children, and gastric discomfort in five adults. Even with these relatively mild complications, we have discontinued therapy in those instances. In a few cases, for investigative purposes, intravenous

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From The Department of Dermatology of the College of Medicine of the University of Cincinnati. Meticorten,® meticortelone,® meti-derm,® and meti-derm® with neomycin received from Dr. Harry V. Pifer, Division of Clinical Research, Schering Corporation, Bloomfield, New Jersey. This study was aided in part by a research grant (A-2602 C) from the U. S. Public Health Service.

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prednisolone was used. In clinical practice, this is not necessary.

THE PROBLEM OF SECONDARY INFECTION

If there is secondary infection, the metisteroids are protected by oral antibiotic therapy. We do not depend on topical antibiotic therapy in the presence of extensive secondary infection. If the patient is seen late in the course of the dermatitis (second week after onset) and there is more secondary infection than Rhus dermatitis, then corticosteroid therapy is not indicated. We do not believe in the routine use of antibiotic therapy in the very active child with poison ivy dermatitis as an insurance against the development of a secondary pyoderma. In our series, we have not had any cases of secondary infection which we felt were aggravated by the oral metisteroid therapy.

TOPICAL CORTICOSTEROID THERAPY

There is considerable confusion existing regarding the value of topical corticosteroid therapy in poison ivy dermatitis. In our present series, we have limited ourselves to 1 per cent and 0.5 per cent meticortelone® mixtures[2, 3] with and without neomycin. It is indeed difficult to see how a large bullous lesion can be "cleared" with topical corticosteroids alone. So, in the average case of vesiculo-bullous lesions, topical corticosteroid therapy is worthless and a needless expense to the patient. However, for early lesions and especially mild lesions of the face about the eyelids, topical corticosteroid therapy may be effective. Clinically, we have observed no evidence of apparent absorption in those few investigative studies in which the entire body was inuncted with topical metisteroids. No hormone assays or metabolic studies were done in these patients.

Moreover, topical corticosteroid therapy used alone was associated with the development of secondary infection. In this series, there were two patients with secondary infection. In one instance, after three days of topical hydrocortisone without antibiotic, an extensive cellulitis of the thigh developed. In another patient, five days after the use of hydrocortisone plus antibiotic, lesions on the hands became pustular and the hands edematous.

Topical meticortelone® in combination with neomycin was used in children to attempt to prevent secondary infection of the lesions even when the child was on oral metisteroid therapy. As the dermatitis began to subside, an effort was made in the adult patient to use topical metisteroid therapy with smaller amounts of oral therapy. It was not possible to evaluate the results critically in this group as to the real value of the topical metisteroid plus neomycin medication.

THE EFFECT ON THE IMMUNE MECHANISMS

The study of the effect of the metisteroid on the immunity of the patient to additional episodes of dermatitis was limited to the uncommon patient who has repeated episodes of Rhus dermatitis each season. An effort was made in some patients to allow the first episode to heal spontaneously, then to treat the next episode with metisteroids. In other patients in this group, the first episode of the season was treated intensively with metisteroids. Again, it was not possible to be certain that the same degree of direct or indirect exposure (tools, animals, insects) had been present before each episode. Moreover, there is marked variation of sensitivity in the same individual, not only from season to season, but also during the same season.

In our experience, quantitative so-called patch testing with Rhus extract does offer some aid to determine, roughly, the degree of the patient's sensitivity at that time. We still believe it to be of doubtful value in the detection of slight differences. This technic was not used in our present series. We still employ this type of skin testing chiefly to attempt to evaluate the possible value of preseasonal oral Rhus extract.

In patients with repeated episodes each season, the response to oral metisteroids was good each time. There was no evidence of resistance to therapy. That type of patient insists on prompt therapy with metisteroids. So, at the present time, we cannot tell what the corticosteroids do to the immune mechanism in the hypersensitive patient. In this series, no post-treatment urticaria was observed.[1]

It is important to emphasize that the clinical picture of dermatitis may be changed by the administration of corticosteroids, and, at times, the diagnosis of Rhus dermatitis was not evident at first, unless the linear character, for example, of the eruption was maintained. This feature of corticosteroid effect on the clinical picture of a treated dermatitis is not limited only to dermatitis from poison ivy, but is a factor in modern dermatologic practice.

CONCLUSIONS

Adequate oral metisteroid therapy can help the dermatitis from poison ivy or oak. Unless contraindicated, it should be employed always for the case classified as severe. For this moderately severe case, it may be employed if indicated. For the mild case, it need not be used. Topical metisteroid therapy is of no value in poison ivy dermatitis, except for mild lesions, especially about the face.

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Some Considerations on the Management of Perineal Trauma, Especially in Childhood

C. MARSHALL LEE, JR., M. D.; HELMUT MATTHEIS, M. D., and B. N. CARTER, II, M. D.

WITH regard to perineal trauma generally, and more particularly to so-called impalement injuries and related wounds, there is actually little or nothing that can be said that is new. But since, in civilian practice, such injuries are relatively uncommon, an occasional review of the subject is useful to maintain an awareness of the principles governing their management.

In World War II, when infantry techniques required that troops advance or take cover in the prone position, penetrating wounds of the rectum and perineum were quite common, and many useful contributions on the subject resulted from this experience.[1, 3, 4] While there was minor disagreement among various authors regarding technical detail, certain general principles have become accepted.

These include completely defunctionalizing colostomy proximal to a rectal wound, and drainage of the wound area, with or without closure, by either the transabdominal or the perineal route. Suprapubic cystostomy is frequently, but not always, necessary when the bladder or urethra has been torn. No amount of antibiotic therapy can protect against failure to observe these general principles, when the bladder or extraperitoneal rectum have been perforated, especially when, under combat conditions, the time interval between injury and treatment may be prolonged, and when mass casualties and multiple wounds in the same individual are common.

PERINEAL TRAUMA AS AN ENTITY

If injuries to the bladder, rectum or urethra incident to massive fractures of the pelvis, and similar cases of combined trauma are excluded, and if attention is thus confined to impalement injuries and traumatic perineal lacerations, such accidents are quite uncommon in civilian practice. It is often stated in the literature, and is probably true in rural areas, that these injuries are most frequently seen in adult males. However, Fox,[2] in 1951, reporting from Chicago, found two cases in 101,659 admissions to a general hospital, and four cases in 51,427 admissions to a children's hospital. All of his patients were 15 years old or younger, with four females and two males.

Our experience in the Cincinnati General Hospital and Cincinnati Children's Hospital coincides with his. In the 14 years from 1942 to 1955 inclusive, there have been 24 such cases, 12 in each institution, for an average of slightly less than two cases a year. Of the total, only one patient was over 16 years of age, and there were 18 females and six males. Representative data, in Chicago and Cincinnati, therefore suggest that, in metropolitan areas at least, these are predominantly accidents of childhood and that the incidence is two to three times as great in females as in males.

The most treacherous characteristic of these injuries is that their extent and severity may not be appreciated on initial examination, especially when the patient is seen soon after the accident. This is particularly true of penetrating wounds, as compared with lacerations. In the former, even though the wound of entry may be small and innocuous looking, not only may vital extraperitoneal structures be injured, such as the urethra, the vagina, the bladder, and the rectum, but there are abundant recorded cases of single or multiple intra-abdominal injuries, including the large and small bowel, uterus, pancreas, stomach, and even the liver and diaphragm. Structures as remote as the kidneys have been penetrated through perineal wounds of entry, and although we have found no recorded instance of laceration of the spleen by this route, there is no reason that such an accident could not occur.

Traumatic lacerations of the perineum may be

This paper was presented before the Committee on Trauma, of the American College of Surgeons, meeting at Cincinnati, Ohio, February 3, 1956.

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equally serious, as exemplified by the single fatality in our series of cases, to be briefly described below. Though they are likely to be less treacherous than puncture wounds, because the existence of major injury is more obvious to casual inspection, the true extent of the wound may not be appreciated even under fairly close scrutiny. Moreover, it is easy to overlook the important fact that since most such lacerations are inflicted by blunt or at least relatively dull agents, contusion, with delayed swelling, ecchymotic hemorrhage and excoriation may complicate the injury in ways that are not apparent when the initial examination is conducted.

Nearly a third of the cases in our experience resulted from straddling falls on pointed wooden or iron fences. Another typical accident pattern is falling from trees or walls into thick bushes, or in leaf piles, where hidden branches, iron bars or stiff wires may inflict the injury without being accurately identified. The humane instinct of physician and layman alike, which abhors inflicting needless fear or pain on an already frightened child, may lead to tragic errors of omission in the management of such wounds, unless their potential seriousness is fully appreciated.

ACCURATE DIAGNOSIS

We believe that a systematic series of diagnostic steps will lead to accurate appraisal of the injury and forestall many serious and preventable complications. These may be tabulated as follows:

1. With the exception of obviously superficial abrasions, all p a t i e n t s with perineal wounds should be admitted to the hospital and the penetrating instrument should be identified, if possible.

2. Assessment of vital signs, for internal or external blood loss, shock, and over-all condition for general anesthesia should be conducted as rapidly as possible.

3. If the patient can void, the urine is examined for blood. If he cannot void, catheterization should be performed by a physician (it should not be delegated to a nurse) capable of recognizing laceration of the urethra without undue trauma by the catheter. If the urine is bloody or scanty, or both, the catheter is left in place so that a cystogram can be made.

4. Careful, but gentle, digital examination of the rectum should be done in the admitting room (if the child is reasonably cooperative), and the glove is inspected for blood. It must be remembered that small puncture wounds of the rectum may not be palpable.

5. Roentgenographic study is then done with plain films in lateral and frontal upright projections, which are searched for evidence of pneumoperitoneum. Barium enema should not be done. The films should include the pelvis and hips and the possibility of bone injury should be kept in mind.

6. In most children below the age of 15, a light general anesthetic is advisable, to permit vaginoscopic, proctoscopic and even sigmoidoscopic examination, **w i t h o u t** a preliminary cleansing enema. If the rectum contains stool, this is all the more reason not to give an enema, but suction may be employed through the proctoscope.

If close attention to all details of this examination fail to yield evidence of rectal, vaginal, urethral, vesical or intraperitoneal injury, the wound itself is explored for vegetable matter, clothing or other foreign material, a puncture wound being enlarged, if necessary, to assure an effective search. The wound is then thoroughly irrigated, bleeding is controlled, and small deep wounds are left open, without suturing. When restoration of essential anatomical integrity compels surgical repair, a loose closure is used, with catgut sutures in the deep layers. The closed wound should always be drained, though the drain need not be large and bulky.

Either tetanus toxoid or antitoxin, or both, are given, as circumstances require, and in the presence of deep wounds or those with appreciable devitalized muscle, large doses of penicillin should be given as prophylaxis against gas gangrene. The danger of serum sensitivity far outweighs the questionable value of gas gangrene antitoxin.

CLOSE CLINICAL OBSERVATION

During the first 48 to 72 hours after admission, frequent clinical examination of the abdomen and close observation of the temperature and pulse rate, and repeated white blood cell and differential counts are essential to continued vigilance regarding unrecognized intraperitoneal injury. It should also be remembered that even in the absence of actual urethral laceration, perineal contusions may produce enough edema or hematoma to cause urinary retention.

In 1896 Van Hook reported the mortality rate of intraperitoneal wounds inflicted through the perineum as 71.4 per cent. Tillmann, in 1905, reported 78.5 per cent, and Habhegger (1912) recorded 76.4 per cent. For extraperitoneal injuries of hollow structures these three authors agreed on a mortality rate of about 10 per cent.[5]

There was only one death in the 24 cases here reviewed, and this occurred in the only adult patient. He was a 41 year old white male with a 20 year history of chronic alcoholism, and repeated previous admissions to the General Hospital for gonorrhea, gonorrheal arthritis, acute and chronic alcoholism with delirium tremens, and cirrhosis of the liver. In October 1945, after a 3 day drinking bout, he fell across the edge of a chair and sustained a deep perineal laceration which extended through the anal sphincter and

through large hemorrhoids. He refused hospitalizaton until 48 hours after the accident.

He was treated with penicillin, whole blood transfusions, etc., and the wound was left unclosed. No perforation of the urinary tract was demonstrated. Colostomy was not done. On the sixth day after admission he apparently went into septic shock, his blood pressure fell to 75/30 and did not respond to blood transfusions. He died the same day, and autopsy disclosed an abscess of the space of Retzius which could be traced to the perineal wound. He also had left lower lobe pneumonia and cirrhosis of the liver. Although his injury was 48 hours old on admission, it is possible that a colostomy might have saved his life.

If this patient, and one other, in whom the interval was 24 hours, are excluded, the average interval (in the remaining 22 cases) between injury and admission was 4.2 hours, the shortest being 30 minutes and the longest 8 hours.

The mortality rates noted above were, of course, recorded long before the advent of sulfonamides or antibiotics, but this does not imply any greater security with respect to present-day injuries of a similar nature. The mortality and morbidity rate can be held to a minimum only when the interval between injury and treatment is short, when meticulous diagnostic appraisal is conscientiously performed, and when treatment is based on respect for the enormous potential for trouble in such wounds, and a thorough understanding of the principles which govern their management.

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Diseases of the Esophagus

Esophageal atresia with tracheoesophageal fistula has always been a fatal anomaly until surgical correction made possible salvage of many infants. The condition should easily be recognized and treatment promptly instituted.

Esophageal diverticula should be considered in all patients with dysphagia and rumination. Secondary pulmonary diseases due to aspiration are common complications. Surgical removal is easy and effective in competent hands.

Esophagitis is due to peptic action on the vulnerable esophageal mucosa in most instances. A conservative approach to benign lesions at the cardia to prevent or correct gastric reflux is emphasized.—John M. Carey, M. D., and Allen E. Greer, M. D., Oklahoma City: *J. Oklahoma M. A.*, 50:8, January, 1957.

Chlorpromazine-Induced Jaundice And Agranulocytosis

In addition to the milder side effects of chlorpromazine (thorazine,® largactil®), serious reactions may occur. Because of the hazards involved and the seriousness of the hepatitis and agranulocytosis that may result, it is essential that the present status of these events be reviewed. . . .

A study has been made of the better documented reports of chlorpromazine jaundice and agranulocytosis. The important features of these complications have been reviewed.

Chlorpromazine-induced jaundice is of the intrahepatic cholestatic type, and there is usually no associated hepatocellular damage. Nevertheless, several deaths from chlorpromazine hepatitis have been reported. Since the clinicopathologic syndrome of primary intrahepatic cholestasis may have diverse causes, the jaundice may offer considerable difficulty in differential diagnosis. Jaundice may occur several weeks after discontinuing the drug, and it may persist for many months, irrespective of the amount of drug given. In cases of obstructive jaundice in which careful questioning of the patient discloses recent intake of even small amounts of chlorpromazine, operation should be deferred until a complete investigation is made to rule out the possibility of drug toxicity.

The transaminase test is valuable in excluding the possibility of concurrent exposure of patients to other hepatotoxic or icterogenic agents or conditions. Increased transaminase activity has been found to precede the development of jaundice from chlorpromazine.

During the first two months of therapy it is recommended that a urinalysis be done for bile twice a week, and that frequent white cell counts be made during this period and whenever else indicated, especially when fever, sore throat, or skin eruption suggests the presence of sensitivity to the drug. If the blood serum appears icteric, serum bilirubin, alkaline phosphatase activity, and other liver function studies are indicated, as all cases of toxic reactions should be carefully studied. However, no laboratory data can be substituted for careful, continued, clinical observation of the patient.

It would seem wise to avoid chlorpromazine therapy when infectious hepatitis is endemic, in the presence of liver disease, in malnourished patients, and when other potentially hepatotoxic agents have been used. Sparine® (brand of promazine) can be safely given if a patient has previously been sensitive to chlorpromazine.—Wallis L. Craddock, Lieutenant Colonel, MC, USAR, Ft. Douglas, Utah: *United States Armed Forces Medical Journal*, 7:1726, December, 1956.

Retina and Choroid

WILLIAM H. HAVENER, M.D.

THE intimate relationship of these structures necessitates a joint discussion of their pathology. The nutrition of the outer one third of the retina is derived from the choriocapillaris rather than the central retinal vessels, and choroidal vascular changes may therefore produce retinal degenerations. Inflammatory changes commonly involve both structures, hence the term, "chorioretinitis."

Their pathology will be outlined as:

(1) Congenital

(2) Degenerative

(3) Vascular

(4) Inflammatory

(5) Traumatic

(6) Neoplastic

(1) CONGENITAL

A) *Nevus* of the choroid is a common, benign pigmented lesion varying from black to gray depending upon the optical density of the overlying retina. They are always deep to the retinal vessels. They are not progressive, elevated or vascularized, nor do they produce visual defects —characteristics of malignancy.

B) *Medullated nerve fibers* represent visible patches of myelin sheathing of the nerve fiber layer of the retina, and are therefore invariably oriented with the anatomic distribution of the nerve fibers. They are characteristically a clear grayish white, usually with fine "feathery" edges. Most, but not all, lie in opposition to the disc. Being in front of the rods and cones, they produce a blind spot.

C) *Coloboma* designates a defect in closure of the fetal fissure of the floor of the optic cup. These lesions are always in the 6:00 meridian and may involve optic nerve, retina and choroid, ciliary body, lens, or iris. They appear as gaps through which sclera is visible, and are usually lined by irregular pigmented deposits.

D) *Retrolental fibroplasia* is a vascularizing, cicatricial response of the premature retina to excessive concentrations of oxygen. Almost pathognomonic are the visible ciliary processes pulled out behind the iris by the contracting detached retina which forms a gray membrane behind the lens. Peak incidence occurs in the smallest prematures. During the past 10 years it caused more blindness in children than all other etiologies combined! Restriction of supplementary oxygen to the **minimum** amount necessary to relieve cyanosis and maintain life could have prevented most of this blindness.

Submitted May 14, 1956.

The Author

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(2) DEGENERATIVE

A) *Myopia* may be divided into two groups, a "refractive" myopia with no degenerative component, and an "axial" myopia which often manifests degenerative changes. The "myopic temporal crescent" is a sharply demarcated zone of chorioretinal atrophy just adjacent to the disc, commonly seen in axial myopes. Diffuse pigment irregularity and "washed out" appearance of the retina and choroid are often present. Later circumscribed areas of chorioretinal atrophy may appear posteriorly causing serious visual impairment if the macula is involved. Myopic degenerative changes are progressive with age.

Retinal detachment is a serious sequel to myopic degeneration and will be discussed under "Trauma."

Myopic degenerative changes are responsible for 10 per cent of blindness in the United States.

B) *Drusen* occur very frequently in older individuals, and appear as small, rounded, discrete gray to yellowish dots varying in size up to the diameter of an arteriole, rarely larger. They represent benign hyalin concretions on the elastic membrane between retina and choroid. Being behind the rods and cones, they do not interfere with vision. Genetic factors cause symmetrical distribution in each eye—sometimes peripheral, sometimes central. Drusen are to be differentiated from significant pathology such as exudates, miliary tubercles, or chorioretinitis.

C) *Macular degenerations* are inherited deficiencies in the circulation or neuroepithelium of the macula. Distortion of the macula ensues, with a rather varied appearance which can include pigment irregularity, depigmentation, grayish elevations of the macula, cystic degenerations or hole formation, hemorrhages or protein exudations. These changes are limited to the macula, and although they may completely destroy central vision, peripheral vision is never

disturbed. Macular degeneration is a common cause of visual loss in the elderly.

(3) VASCULAR

A) *Arteriosclerosis* manifests itself as a widening of the arterial light reflex, associated with indentation and displacement of the veins at arteriovenous crossings. Advanced arteriosclerosis produces a burnished, coppery appearance of the arterioles, and the most extreme form may appear as a completely sclerotic, gray streak. These changes are accelerated by the wear and tear of hypertension, hence hypertensive and arteriosclerotic changes commonly coexist.

B) *Choroidal* sclerosis appears as a yellow-orange or gray discoloration of the choroidal vessels, which become more readily visible due to atrophy of the overlying retinal pigment.

C) *Hypertension* is first manifested by the appearance of arteriosclerotic changes more advanced than expected for the patient's age.

Grade III hypertension designates the condition of focal or general arteriolar attenuation, often accompanied by hemorrhages or exudates which result from nutritional damage. Presence of Grade III hypertensive retinopathy indicates serious arteriolar disease throughout the body. Grade IV hypertensive retinopathy has progressed to such advanced damage that *papilledema* exists.

D) *Occlusion* of the *central retinal artery* is the only cause of painless complete monocular blindness occurring within minutes. If seen early, the arterioles are attenuated, often carrying a slowly moving broken blood column. The retina is gray and edematous with the exception of the "cherry red" macula. (Choriocapillaris nutrition of the outer retinal layers permits the macula to remain normal in appearance, since it has no inner retinal layers.) Collateral circulation may restore retinal vessels to a normal appearance later, though blindness is permanent. Hemorrhages are usually not present, and are never extensive.

E) *Occlusion* of the *central retinal vein* is characterized by very dilated, tortuous veins, more or less hidden under extensive superficial hemorrhages. Vision is reduced but light perception always remains. Formation of new capillaries is almost pathognomonic of chronic venous occlusion. Small deep hemorrhages or capillary microaneurysms often develop within several months. Branch venous occlusion may exist, with only a quadrant of the retina being involved.

Diabetic retinopathy is a special form of venous stasis characterized by capillary microaneurysms, small deep hemorrhages, and fairly sharp circumscribed exudates. (Exudates represent protein and lipoid residues of localized edema deposits.) Neovascularization and extensive degenerative changes supervene in advanced cases.

F) *Hemorrhages:* The shape and extent of retinal hemorrhages depend in large part upon histologic structure. A *preretinal* hemorrhage lies in the potential space between retina and vitreous, therefore is always in front of the retinal vessels. Being loosely confined, preretinal blood settles out to form a fluid level oriented with gravity. Most of the large vessels lie in the nerve fiber layer, whose bundles run radially toward the optic nerve. Hemorrhage in the nerve fiber layer therefore assumes a *flame-shaped* distribution. In contrast to this, the outer retinal elements are closely packed in a perpendicular fashion, and limit the lateral spread of the *deep-circular hemorrhages* characteristic of the outer retina.

Choroidal hemorrhages are partially concealed by the retinal pigment layer and assume a dark, slate color, always underlying the retinal vessels. Hemorrhages associated with *blood dyscrasias* are rather large and irregular, frequently with a greyish white center.

Microaneurysms are tiny capillary dilatations, less than the diameter of a retinal arteriole, closely resembling a pinpoint hemorrhage. Microaneurysms and new formed tortuous blood vessels are very characteristic of diabetes on occlusion of the central retinal vein. Flame-shaped hemorrhages are produced by central retinal vein occlusion, malignant hypertensive retinopathy, and severe papilledema. Small, deep hemorrhages are often diabetic.

G) *Exudates:* Increased permeability of small vessels permits transudation of lipoid material which gathers in greyish aggregates. Diffuse, fluffy, greyish exudates (cotton-wool patches) represent a process of short duration such as malignant hypertensive retinopathy or venous occlusion. Sharply circumscribed, yellowish, (hard) exudates are formed slowly in long standing pathology such as diabetic retinopathy. Senile macular degenerations may produce a halo of hard exudates about the macula *(circinate retinopathy)*. Hypertensive retinopathy tends to cause a *macular star figure* of radiating exudates.

H) *Retinitis proliferans:* In diabetes, tuberculosis, and trauma, a new network of vessels may form on the retinal surface and extend out into the vitreous. Glial membranes commonly accompany these vessels. Vision is usually severely damaged by these newly formed vessels and membranes.

(4) INFLAMMATORY CHANGES

A) *Chorioretinitis* is believed to be a focal allergic response of the choroid and adjacent retina to a variety of bacterial antigens. Localized chorioretinitis is classified anatomically as macular, peripheral, or juxtapapillary. Disseminated chorioretinitis involves large areas of the fundus and is often luetic. An active chorioretinitis is greyish-yellow, nonpigmented, hazy in outline due to surrounding edema, is sometimes

hemorrhagic, and often causes vitreous opacities. Scars of old, inactive chorioretinitis are usually surrounded by dark pigment, are discrete and non-edematous, and may reveal underlying choroidal vessels and sclera.

B) *Perivasculitis* refers to a greyish "sleeve" of inflammation accompanying the retinal vessels, more commonly the veins. Such a lesion should always be examined minutely since it commonly leads to an area of peripheral chorioretinitis. Tuberculosis is often alleged to be the etiology of periphlebitis.

(5) TRAUMATIC

A) *Retinal separation* occurs whenever a retinal tear (due to injury or degeneration) permits fluid vitreous to seep through and displace the retina away from the choroid. The detached retina has a greyish, undulating appearance, crossed by sinuous and dark retinal vessels. The tear (which must be found and sealed to effect a cure) is usually in the far periphery. Unusually dark and solid detachments result from choroidal malignant melanomas.

B) *Striate retinopathy* refers to the irregular folds and scars resulting from post-traumatic hemorrhage and gliosis.

C) *Commotio retina* is the greyish edema, most marked at the macula, resulting from ocular contusions.

(6) NEOPLASMS

A) *Retinoblastoma* is a dominantly inherited malignant mutation manifested in childhood. Arising from one or multiple foci, monocular or binocular, it appears as a greyish, rounded elevation of the retina Untreated, growth is rapid and lethal.

B) *Melanoma* of the choroid is a highly malignant tumor of adult life. Pigmentation, slight to marked elevation, vascularity, and growth are characteristic.

C) *Metastatic carcinoma* may invade the choroid, appearing as a greyish nodule.

D) *Phakomatoses* include tuberous sclerosis, neurofibromatosis, encephalotrigeminal angiomatosis, and Von Hippel-Lindau's syndrome of cerebellar and retinal angiomatosis. All these may produce ocular tumors.

Undesirable Reactions To Antibiotics

In summary, antibiotics produce undesirable reactions by sensitization, by direct toxicity, or by the initiation of superinfections. They are dangerous drugs and should be prescribed only when there are clear clinical indications for their use; likewise, the decision to prescribe an antibiotic should be made only after balancing possible ill effects against expected benefits.—Ivan L. Bennett, Jr., M. D., Baltimore Md.: *West Virginia M. J.*, 53:55, February, 1957.

The Ocular Manifestations of the Sturge-Weber Syndrome

The Sturge-Weber syndrome, or encephalotrigeminal angiomatosis, is the combination of a hemangioma of the skin, usually over the area of distribution of one or more branches of the fifth cranial nerve (nevus flammeus), glaucoma, and angiomatous changes in the vessels of the meninges of the brain. Nevus flammeus may be associated with glaucoma without meningeal involvement, or with a meningeal angioma without glaucoma. The incomplete forms are more frequent than the complete syndromes. When present, the facial lesion and the glaucoma almost always occur on the same side.

Numerous instances of the association of glaucoma and facial hemangioma have been reported. The syndrome has been well reviewed in the literature (Ballantyne,[1] O'Brien and Porter[2] and Joy[3]). Nevus flammeus is usually unilateral but may be bilateral, and, when associated with glaucoma, involves the lids or conjunctiva. Glaucoma is either buphthalmic or the chronic simple type.

The ocular findings associated with nevus flammeus are dilated conjunctival vessels, vascular nevus of the conjunctiva and the episclera, peripheral anterior synechiae, heterochromia iridis, dense stroma of the iris, dilated vessels of the iris, varicose vessels of the iris, hemangioma of the iris, tortuous retinal vessels, varicosities of the retinal veins, dark red fundus, changes in the pigment epithelium of the retina, retinal detachment, dilated and tortuous choroidal vessels, hemangioma of the choroid, and cavernous atrophy of the optic nerve. The most common intraocular vascular change is a hemangioma of the choroid.

Choroidal hemangiomas frequently occur as isolated lesions, and are considered by Berliner[4] to be variants of the Sturge-Weber syndrome. They present a difficult diagnostic problem when observed clinically and are usually mistaken for malignant melanomas. Most globes in which angiomas of the choroid are found upon sectioning in the laboratory, are either enucleated because of suspected melanomas or because of the presence of absolute glaucoma of unknown cause.

The neurologic symptoms, which are due to intracranial hemorrhage from the abnormal vessels of a diffuse meningeal hemangioma, are listed by Anderson.[5] They are localized and generalized epileptiform seizures, hemiplegia, hemianopia, mental deficiency, contralateral homonymous hemianopia, and epilepsy.—J. Jack Stokes, M. D., Atlanta, Ga.: *Southern M. J.*, 50:82, January, 1957.

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A New Concept in the Treatment of Acne Vulgaris (N¹Sulfanilylacetamide)

A. HARVEY NEIDORFF, M. D.

ACNE vulgaris has been attributed to various causes in an attempt to define its etiology. Among the possible factors are hormonal aberrations, improper cosmetics, rough garments, chemical contacts, uncleanliness, hypovitaminosis, et cetera.

ANDROGENIC THEORY

The opinion of most investigators[1] seems to have resolved the explanation primarily into the theory of androgenic hormone excess accompanied by hyperactivity of sebaceous glands with consequent plugging of the pilosebaceous apparatus frequently complicated further by pyogenic infection and the presence of pustules and cysts. Regardless of rationale the unhappy victim of this condition has become a common sight in the physician's office.

The purpose of this review is to summarize some of the aspects of acne therapy and to report our experience and observations with a chemotherapeutic agent (N¹Sulfanilylacetamide) not previously employed in this condition.

Since a definite reason for acne development has not been established a specific cure is not presently available. Treatment of the patient has therefore been directed towards obtaining symptomatic relief—primarily by resorting to topical therapy and x-ray treatment with the object of causing superficial peeling, drying, antiseborrheic and desquamating action.

MANAGEMENT

Medical management has been best achieved by thorough cleansing with mild detergents and local application of lotions containing resorcin and sulfur. Over a period of years however, we observed that a number of severe and stubborn acne eruptions would not yield to this routine therapy. These obstinate cases were generally of the pustular and cystic type and the sequela of facial disfigurement and scarring was thus frequently incited. We began therefore to explore the newer drugs for one which would prove of value in inveterate acne, either as a replacement for or synergistic to resorcin and sulfur.

Our procedure in this investigation was to segregate the recalcitrant and unmanageable acne cases who had already had x-ray to tolerance and the usual local applications without effect. The new drug under scrutiny would then be employed either *per se* or with resorcin and sulfur to determine whether it possessed any superior action or advantages to previous therapy.

Submitted September 5, 1956.

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About a year ago a lotion[2] containing N¹Sulfanilylacetamide 8.5 per cent with resorcin 2 per cent and sulfur 5 per cent was made available to us. This preparation employed in extremely severe cases of pustular and cystic acne proved of great value, causing retrogression of the pustules with reduction in sebaceous hyperactivity and general clearing of the lesions. At this time we had a group of 47 patients with intractable acne vulgaris ranging in age from 14 to 30. These patients who had not responded to previous therapy were given 2 ounce bottles of this lotion and instructed to apply it two or three times a day. It was apparent almost immediately that the lotion was extremely effective. Of these 47 obdurate cases, 31 had excellent therapeutic response, nine had good results, five had fair response and two had no improvement. The average duration of application was three to five weeks.

As a further check of the effectiveness of this medication we decided to employ it in a controlled study of unselected acne patients whose final number reached 125. In "paired comparisons" with these additional cases the resorcin and sulfur lotion containing the N¹Sulfanilylacetamide was applied to the left side of the face and the plain resorcin and sulfur lotion was applied to the right side. The average duration of application was three weeks. The bottles were identified only by the word right or left and both lotions were identical in appearance, being flesh-colored, cosmetically acceptable products assuring daytime use and patient cooperation.

The results with the N¹Sulfanilylacetamide lotion were uniformly and unvaryingly superior within a much shorter interval of time. Of the 125 patients in this study with varying degrees of involvement 94 per cent were completely cleared on the side of the face to which the N¹Sulfanilylacetamide lotion with resorcin and sulfur was applied. The other side to which the plain resorcin and sulfur lotion was applied showed 69 per cent clearance and took much

longer. It is interesting that in this program, although both lotions were identical in appearance a few patients recognized the superiority of the N¹Sulfanilylacetamide lotion and regardless of instructions used it over the entire facial area.

There was virtually no sensitization to this lotion. One mild reaction was traced to the resorcin.

A study of the available literature on N¹Sulfanilylacetamide showed it to have an extensive clinical history of completely safe and relatively nonsensitizing use in occular infections.[3, 4, 5] N¹Sulfanilylacetamide has also been widely used in urinary infections.[6] Recently it has been reported effective and nonirritating in the treatment of seborrheic dermatitis of the scalp.[7]

As far as we can ascertain the theoretical rationale for the use of this chemical is based on the paralinkage of the sulfur in the N¹Sulfanilylacetamide. When present on the acne skin it apparently prevents multiplication of the bacteria and provides the integral defense mechanism with the opportunity to neutralize the invading organisms.[8] This is apparently accomplished without the acquired bacterial resistance characteristic of the topical antibiotics or sensitization induced by most sulfonamides. N¹Sulfanilylacetamide exerts potent bacteriostatic action against a wide range of gram-positive and gram-negative microorganisms. The activity demonstrated by the N¹Sulfanilylacetamide seems to be related to its interference with the essential metabolism of bacteria imbedded in the sebaceous glands in secondary pyogenic infections.

SUMMARY

1. A chemotherapeutic agent (N¹Sulfanilylacetamide) not previously employed in acne vulgaris has been subjected to controlled clinical studies.

2. This bacteriostatic drug in combination with the keratolytic and antiseborrheic action of resorcin and sulfur, has proven dramatically effective in the treatment of acne vulgaris, particularly in stubborn pustular and cystic types.

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KEEPING UP WITH MEDICINE

• THE CUMULATIVE evidence that each individual human being has a distinctive pattern of enzyme efficiencies is hard to refute on any rational basis.

* * *

• URTICARIA due to heat can be divided into the generalized type (cholinergic) produced by heat, exercise and emotional stress and a non-cholinergic "local" type produced by heat alone.

* * *

• WHEN TWO INDIVIDUALS of the same weight and height yield total metabolism values that are about the same, it is easy to conclude that their metabolisms are substantially identical, yet Roger J. Williams has shown that the extent to which specific reactions may take place may vary in the two individuals as much as tenfold!

* * *

• MOST HEAD INJURIES of consequence occur as a result of forces which are likely to cause cervical injury involving ligaments, disks, or bones. These may be forgotten unless special examination for their presence is made.

* * *

• ECZEMA SOLARE is probably an allergic eruption, for lesions resembling it very closely are regularly seen as an allergic response to eczematogenic contact allergens.

* * *

• HORTON'S SYNDROME does not behave like migraine, but does share with it localized vasodilatation of the branches of the external carotid artery. It occurs most in men (in men under stress who never take a vacation). It consists of a batch of attacks occurring every day or night and often several times in a single 24 hour period. Some have only one or two batches in a lifetime and in others they are of increasing frequency.

* * *

• TOLYLENE DIISOCYANATE used in the manufacture of polyurethane foam is an allergic substance capable of producing human sensitivity with resulting asthma-producing bronchospasm in the minutest quantity upon re-exposure of the sensitized person.

* * *

• PATIENTS who have sustained a perforation of a peptic ulcer are subject to further gastric difficulties in 70 per cent of cases.

* * *

• ALTHOUGH not common, urticaria caused by cold is not a rare disease. It occurs in cryoglobulinemia, in syphilitic paroxysmal cold hemoglobinuria and in essential cold urticaria. The presence of cold agglutinins in the blood is not associated with such sensitivity. The condition is probably an allergy since the results of passive transfers compare favorably with those seen in drug-induced hives which presumably have an allergic base.—J. F.

The Serum Transaminase Assay*

TRANSAMINASE is one of the soluble intracellular enzymes appearing in the bloodstream when tissues break down. Transaminase is present in normal sera in an average concentration of 20 units per milliliter (normal range 7 to 40 units/ml). A transaminase level of more than 50 units/ml. may be considered as indication of tissue breakdown and only that. Values in the range 41 to 50 units/ml. are considered to be borderline.

Over 90 per cent of individuals with myocardial necrosis exhibit elevated transaminase activity. There is a characteristic pattern of change in the transaminase activity in myocardial infarction. The transaminase concentration generally begins to rise 6 to 12 hours after the onset of pain, reaches a peak value about 24 to 36 hours after the onset of pain, begins to decline about the third day, and returns to its normal level in 3 to 6 days following the attack. The peak transaminase activity is usually *2 to 20 times the normal level,* averaging 200 units/ml. (range 80 to 600 units/ml.). There appears to be a rough correlation between the transaminase activity at the peak and the extent of tissue involvement in myocardial infarction.

Transaminase activity is also elevated *(some 20 to 100 times greater than normal)* in hepatitis whether due to toxic or infectious agents. Studies of transaminase activity can thus serve as a sensitive liver function test. However, in *liver injury,* not only is the transaminase activity generally much *higher than in myocardial infarction, but* it tends to *remain elevated longer* (at least 30 days).

In patients with suspected myocardial infarction it is recommended that blood be taken within six hours of the onset of pain (for the base transaminase level); at 30 to 40 hours (for an estimation of the peak value), and at 5 to 6 days (to differentiate between elevations due to myocardial infarction and hepatic tissue necrosis). In myocardial infarction the transaminase activity should be nearly back to normal on the fifth or sixth day; in liver necrosis it would still be elevated.

Transaminase activity is not elevated in infectious, degenerative, neoplastic, allergic, reactive, or congenital disease state unless these are associated with acute damage to heart or skeletal muscle, or to liver or kidney. Transaminase activity is not elevated in angina pectoris or coronary insufficiency unless accompanied by heart muscle damage. Transaminase levels are elevated in some cases of cirrhosis of the liver, are moderately high in extrahepatic obstructive jaundice, and generally are elevated in primary or metastatic carcinoma of the liver. Transaminase activity may also be high in acute pancreatitis and in some cases of active rheumatic carditis.

Either serum or plasma may be used for the determination of transaminase activity. The anticoagulant in the plasma may be either citrate, heparin, or oxalate. Hemolyzed serum or plasma yield falsely high results and should not be used. Serum for the transaminase test may be stored for several days in the refrigerator without appreciable loss of enzymatic activity.

The transaminase level in a normal individual is relatively constant from day to day (does not vary by more than 10 units) and is not appreciably affected by the time of day, relationship to meals, or exercise. However, the analysis of serum which is lipemic or bilirubinemic involves technical difficulties which may prove to be insurmountable in some cases.

RESUMÉ OF VALUES

	Range	Average
"Normal"	7-40 units	20 units
Borderline	41-50 units	
Myocardial infarction	80-600 units	200 units
Hepatitis	150-2000 units plus	

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*Those desiring reprints of this article may secure them by writing to the Ohio Society of Pathologists, 267 E. Broad Street, Columbus 15, Ohio.

Submitted December 20, 1956.

The Author

● Prepared for the information of all Ohio physicians by the Ohio Society of Pathologists.

Epidemic (Arthropod-Borne Viral) Encephalitis in Indiana

From the experience of Indiana, Illinois and Kentucky in 1955 and the more recent experience of Kentucky in 1956, it appears that there is a reservoir of St. Louis virus in some species of birds in the Ohio River Valley.

The occurrence of mosquitoes as the vector and the incidence of primary cases of virus encephalitis infections in August, September and early October should make the practitioner suspicious of St. Louis encephalitis.—Albert L. Marshall, Jr., M. D., Indianapolis: *J. Indiana M. A.*, 50:38, January, 1957.



A CONTINUOUS state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and assisted by official representatives of the various County Medical Societies of the state.

Since work of the committee is educational as well as statistical, summaries of some of the cases studied by the committee, based on anonymous data submitted, will be published in *The Ohio State Medical Journal* from time to time. Each presentation will be brief but informative. It will contain opinions of the committee, based on the data submitted for review. In the series of cases, entitled "Other Causes," the three cases in this seventh report have to do with maternal death due to pulmonary emboli.

CASE NO. 58

This patient was a 37 year old, white, Para 0, cesarean IV, abortion II, ectopic I, who suddenly died two days post-cesarean operation. Her past history showed that she had poliomyelitis as a child with residual atrophy of the right lower extremity. At the age of 18 she had orthopedic surgery upon the right lower leg, complicated by phlebitis. The initial cesarean section was done in 1939 at 36 weeks' gestation. The indication was funnel pelvis; it was confirmed by x-ray. Repeat cesarean sections were done in 1950 and 1951, all with living children. In 1946, the patient had an early abortion. In 1947, she had an ectopic pregnancy and, in 1953, had an early abortion with dilatation and curettage. Her prenatal course was uneventful. Prenatal care was considered adequate.

The patient was admitted to the hospital July 14, at 36 weeks' gestation for elective repeat cesarean section. On July 15, at 8:35 a. m. she was delivered by classical cesarean section of a living male child weighing 7 pounds and 5 ounces. No apparent difficulty was encountered during or after the operation. The type of anesthesia used was not recorded. An uncomplicated afebrile course followed. On July 17, the patient felt quite well. While walking with her husband she suddenly collapsed and expired. Autopsy permission was granted.

Pathological diagnosis: (1) Massive pulmonary embolus. (2) Status two days post-cesarean section. (3) Atrophy right lower extremity, post-poliomyelitis type. (4) Slight edema of left lower extremity. (5) Slight pulmonary congestion and edema. (6) Slight early bronchopneumonia. (7) Slight dilatation of heart. (8) Cloudy swelling, myocardial fragmentation. (9) Slight metamorphosis of liver. (10) Focal necrosis malphigian bodies of spleen. (11) Exophageal ulceration and esophagitis.

COMMENT

The Committee considered this case a nonpreventable maternal death. There was some question concerning the site from which the pathologist thought the embolus arose. The state of postparalytic atrophy could only be a coincidental condition since it apparently did not interfere with her early ambulation.

CASE NO. 73

This patient was a 32 year old, Para III, gravida V, who died suddenly three days after normal vaginal delivery. Nothing of the patient's past history was known. She allegedly had adequate prenatal care by a physician and her prenatal course was uneventful; details were not recorded.

The patient was admitted to the hospital August 22, in active labor with membranes ruptured five hours preceding. After 15 minutes of hospital stay she had an attended spontaneous delivery of a living child weighing 7 pounds and 13 ounces. Open drop ether was used. In the immediate puerperium, the patient experienced a sudden profuse hemorrhage *estimated* at 1,000 cc. Examination showed a 7 cm. laceration of the cervix, which was repaired expediently. A replacement transfusion of two units of blood was given. The condition immediately following was said to be satisfactory. Three days, eight hours and 32 minutes after delivery, the patient went to the bathroom unattended. She was later found face down on the bathroom floor, pulseless. She did not respond to stimulants or resuscitation.

Cause of Death: The clinical impression was massive pulmonary embolism. Autopsy permission was granted.

Pathological diagnosis: (1) Acute nonspecific myocarditis. (2) Status postpartum with laceration of cervix. (3) Pulmonary emphysema. (4) Cerebral edema. (5) Generalized acute passive hyperemia.

COMMENT

The members of the committee felt that this was a nonpreventable maternal death. Considerable time was spent in discussing the path-

ologist's findings. In the absence of more complete documentation concerning the patient's postpartum blood picture, it is only a guess to question whether or not the original blood loss was underestimated and subsequent blood replacement was inadequate. No mention was made of uterine tonus, or results of exploration of the uterine cavity. The entire picture could be explained on the basis of central and generalized effects of anoxia resulting from depleted blood elements.

CASE NO. 107

This patient was a 28 year old, white, Para II, gravida III, who suddenly died four days after normal delivery of twins. Her past history showed normal deliveries in 1951, and 1953, of living, term, children without complications. Her prenatal care was considered adequate with 11 visits. Her normal weight was 196 pounds; she presented for examination in the third month of pregnancy weighing 186 pounds. Her weight gain curve was considered satisfactory. Urine examinations were negative throughout gestation and she had normal blood pressure. The hematocrit at 12 weeks was 44 per cent. The hemoglobin was 13 grams. She was considered "hypothyroid" and was maintained on a dose of thyroid gr. 2 daily.

During her twentieth week she was hospitalized for acute pyelitis. She received antibiotics, one unit of blood, and made an uneventful recovery. During her twenty-eighth week, moderate edema of both lower extremities developed, and she was placed on diamox.® Twin pregnancy was diagnosed during her thirty-second week by x-ray. In her forty-first week of gestation, at 12:00 noon on November 7, she began labor with mild cramp-like pains. She was admitted to the hospital at 5:00 a. m., November 8, weighing 208 pounds, blood pressure 115/80, urine negative, moderately severe edema of the lower extremities. Height of fundus 47 cm. Cervix 5 cm. dilated. Her contractions were every five minutes and mild in character. At 6:54 a. m. she was given a saddle-block anesthesia of nupercaine® at L-4. The first fetus presented frank breech station—1 cm. After a slight drop in blood pressure, her legs were elevated and oxygen was given continuously. Soon the patient's pressure stabilized at 112/80. The membranes were stripped from the lower segment. The first twin delivered spontaneously at 7:25 a. m., and weighed 7 pounds 10 ounces. A pitocin® drip (5 units) in 500 cc. of 5 per cent glucose was started intravenously. The membranes surrounding the second twin were ruptured artificially and at 7:41 a. m. a 9 pound 2 ounce living child was delivered spontaneously. There was a small first degree laceration of the perineum. There was scant postpartum blood loss, estimated at 150 cc. She returned to the postpartum floor at 8:30 a. m.

Postpartum Course: Her first, second and third days postpartum were uneventful. A rapid loss of edema in lower extremity was noted. On November 11, the patient noticed swelling of her right lower leg. At 10:40 a. m., six to eight hours after swelling was noted the patient got up. She had sudden severe dyspnea, shock and chest pain. Her blood pressure was 70/40, pulse 140, respiration 40-50. By 11:00 a. m. her blood pressure was 50/30, pulse 110. She was given oxygen, aminophylline, solu-cortef® in 5 per cent glucose intravenously, and demerol® with good response. The patient was stabilized for 24 hours.

On November 12, a surgical consultant saw the patient and advised immediate surgery of the right femoral vein. At 10:00 a. m., the patient had another embolus episode; pulse and blood pressure were unobtainable; mydriasis, and respiratory arrest ensued. Positive pressure oxygen was given. A continuous electrocardiogram showed ventricular fibrillation. A left thoracotomy was performed and cardiac massage was done for 40 to 50 minutes. The patient was pronounced dead at 11:48 a. m. on November 12. Permission for autopsy was granted.

Pathological diagnosis: (a) bilateral massive pulmonary artery emboli. (b) Phlebothrombosis, acute, extensive, right femoral and external iliac veins. (c) Varicosities of lower legs, accompanying twin pregnancies.

COMMENT

The Committee was pleased to have such a well-documented case for study, and appreciation was extended to the responsible attendants. This case was voted a nonpreventable maternal death. Several aspects of discussion are noteworthy. One member commented on the single transfusion administered during the hospitalization for pyelitis. She had a hematocrit of 44 per cent some time before and the use of only one pint of blood appeared more or less as a cosmetic agent, which is criticized. The Committee discussed the advisability of saddle-type conduction anesthesia for a breech presentation, and delivery of twins; it was felt that the anesthesia was not one of choice. And furthermore it would not seem wise to start it before delivery was imminent.

An additional consideration centered about the firm immobilization of the patient's legs, in stirrups for an hour or so, for delivery; the ordinary obstetrical table is not usually designed to insure competent circulation in the patient's legs. In this particular patient, with edema and questionably efficient circulation, prolonged immobilization of the lower extremities, in "stirrup" position, under conduction anesthesia, could not be considered feasible. Apparently there was not a thorough investigation of pain in the lower extremities, before ambulation; and it would seem that surgical consultation was delayed too long, whether or not it resulted in proper definitive surgery.

COMMENT OF CONSULTANT

The following comment of a consultant, who is a specialist in diseases of the chest, was furnished at the request of the Committee.

Reviewing the cases presented gives rise to some comments regarding pulmonary embolism. This unfortunate situation is usually nonpreventable. It usually is so sudden, the time element between the onset of the illness and cessation of heart beat is so short, that intervention is next to impossible. European reports are more favorable than ours in the immediate surgical intervention of the saddle embolus. This is probably due to an organized adequate team of thoracic surgeons being available at the time of the accident. Although the operation has been done several

times in this country authentic recoveries are lacking.

The previous history of phlebitis always warrants serious consideration prior to delivery, whether it be spontaneous or by cesarean section. There are many who insist that once phlebitis is definitely established, a ligation, either femoral, iliac, or vena caval should be done with impunity. The pregnancy itself complicated this approach considerably. In the presence of chronic long standing phlebitis, it also gives rise to the serious consideration of anticoagulants prior to delivery. This distressing condition has certainly not been solved; neither its prevention nor management.

One thing I would like to point out is the importance of early recognition of pulmonary infarction, as pulmonary infarction may be the forerunner of more serious infarction or embolism. Early infarction is most commonly confused with respiratory infection, the management of which is entirely different. I think any patient following delivery, with any blood spitting, pain in the chest, pain on respiration, slight dyspnea, and with or without x-ray changes, should be seriously considered as a pulmonary infarction, and should be confined to as complete rest as possible by the use of heavy sedation and reduction in all physiological activities. Often this will stabilize the condition and no further trouble will result, while if ambulation, turning, coughing, etc., are continued, further embolic phenomena may follow.

The use of anticoagulants such as hedulin,® etc., is considered by some to be imperative, and by others with more reserve. In my opinion the important thing regardless is early recognition of infarction and physiological rest. The important point of diagnosis is bearing it in mind.

The Contribution of the Tranquilizing Drugs

It is important to be aware of subtle pressures that combine to foster public misunderstanding and misuse of the [tranquilizing] drugs. There is the eagerness of the public, and of physicians themselves, for "good news" about a new treatment for psychiatric disorders. This tends to foster popular stories based on optimistic reports of early and limited research findings with the drugs, before such findings can be reproduced or validated by other colleagues.

Persons engaged in any form of research or evaluation of therapy should be most dispassionate and objective in their pronouncements. It is suggested that members of the American Psychiatric Association be particularly alert to personal pressures (both internal and external) and that they be circumspect in their announcements of early experimental results with the drugs.— By the Committees on Research, Therapy and Public Information of the American Psychiatric Association: *J. Iowa M. Soc.*, 47:66, Feb., 1957.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met at the Columbus Health Center on December 18, 1956, at 12 o'clock noon. Two cases were presented.

Case 39. The patient was admitted with the chief complaint of intermittent vaginal bleeding, first noted three years before. During the three years she had been treated by several physicians, and was given shots for bleeding. She had no pelvic examination until she saw the physician who took papanicolaou smears and when the report came back suspicious, he referred her to clinic. Menopause; 47 years. Examination revealed marked obesity. Pelvic examination revealed a relaxed introitis and vagina with a clean normal positioned cervix. No masses were felt.

The patient had a dilatation and curettage and biopsy of the cervix. A large amount of friable endometrial tissue was obtained and the pathologic report was papillary endometrial adenocarcinoma, Grade III malignancy and chronic cervicitis. She received a total dosage of 8,400 mg. hours of radium. Two months later she had a total abdominal hysterectomy and bilateral salpingo-oophorectomy. Pathologic report was residual endometrial adenocarcinoma, Grade II malignancy.

COMMENTS

DR. JOHN H. HOLZAEPFEL: Three years physicians' delay.

DR. FRANCIS GALLAGHER: Postmenopausal bleeding is not normal. A pelvic examination definitely should have been done.

Case 40: A 74 year old patient who was first seen with a history of vaginal bleeding of two months. She was referred to gynecologist by her internist. Because of menorrhagia the patient had a radiation induced menopause at the age of 37. Pelvic examination revealed a senile introitis and old lacerations. The cervix was clean and freely movable. There was a fine trickle of blood in the os. Uterus seemed small. There were no adnexal masses and rectovaginal examination was negative.

The patient was accompanied by her son and both were advised that a dilatation and curettage were necessary. That the diagnosis was cancer until proven otherwise, was explained to both. In a conversation with the son, he stated that his mother refused to be admitted.

One year later patient called and said she was having bleeding for one week and had been having a discharge for several months. Because of these symptoms she would finally be admitted. A dilatation and curettage and cervical biopsy were done. A moderate amount of necrotic friable tissue was obtained and pathologic report was partially necrotic endometrial adenocarcinoma, Grade III malignancy. She received radium for a total dosage of 4,800 mg. hours.

The patient was discharged, but to date she will not give her consent to return for further treatment.

COMMENT

DR. FRED HAPKE: One year patient delay.

Drug Therapy in Tuberculosis*

HAROLD I. HUMPHREY, M.D.

THERE has as yet been found no safe drug which is bactericidal to the tubercle bacillus. With the present bacteriostatic drugs, however, we are able to retard the multiplication of the bacillus in our patient until his natural forces of resistance can be mobilized to arrest the progress of the disease. These drugs often make resectional surgery possible in the patient who would be too serious a surgical risk without them.

The three most valuable drugs in tuberculosis are isoniazid, streptomycin, and para-aminosalicylic acid. Two other drugs, viomycin® and pyrazinamide, are also helpful in selected cases, but require close supervision to prevent harmful toxic reactions. Cycloserine is still in the experimental phase.

In previously untreated tuberculosis the concomitant administration of any two of the "big three"—isoniazid, streptomycin and para-aminosalicylic acid, will give satisfactory results in most cases, when combined with other forms of therapy. Apparently, there is no advantage in using all three drugs together in most cases. It is most important to use two of the drugs simultaneously and without interruption to obtain best results and to prevent the early development of bacterial resistance.

Streptomycin is given in dosage of 1.0 Gm. intramuscularly twice a week. In miliary, meningeal or serious pneumonic tuberculosis 1.0 Gm. daily may be given for several weeks initially, with subsequent change to 1.0 Gm. twice a week.

Isoniazid is given orally in dosage of 3 to 5 mg. per kilogram of body weight per day, in two or three divided doses. As much as 10 mg. per kilogram of body weight daily has been given, but about 10 per cent of patients on this high dosage develop peripheral neuritis.

Para-Aminosalicylic Acid (PAS) is given orally, 12 to 16 Gm. of the sodium salt daily for the average adult, divided in three or four doses. Some patients exhibit gastrointestinal intolerance to this amount of PAS. If this occurs, the daily dose may be reduced to 5 or 6 Gm. daily without losing much of the beneficial effect, if the drug is combined with isoniazid. As large a dose as tolerated, up to 16 Gm. is to be preferred, however.

Viomycin® is helpful in the event that the patient's tubercle bacilli become resistant to isoniazid or streptomycin. It is not as powerful a bacteriostatic agent as isoniazid or streptomycin, and is more toxic. Tubercle bacilli readily become resistant to viomycin.® The dose is 1.0 to 2.0 Gm. twice a week, intramuscularly. It may be advantageously combined with isoniazid or pyrazinamide, but should not be used with streptomycin due to the danger of a neurotoxic effect on the eighth cranial nerve. It should be used cautiously in patients with poor renal function due to the possible accumulation of toxic concentrations in the blood. It should probably be used only in the hospital where the patient can be kept under constant observation.

Pyrazinamide (PZA) is an efficient anti-tuberculosis drug, but one to which bacterial resistance develops rather rapidly. It may be combined with isoniazid, PAS, or streptomycin. Unfortunately, it is toxic to the liver in a small percentage of patients, and should not be used in a patient with liver damage. However, a seriously ill patient, or a prospective surgical patient resistant to other drugs may benefit greatly from its use. The physician is justified in taking a calculated risk in such cases. PZA is not recommended for use outside of the hospital due to possible toxicity.

RECOMMENDED THERAPY FOR PULMONARY TUBERCULOSIS

In adult patients, isoniazid in dosage of 300 mg. daily and sodium PAS in dosage of 12 to 16 Gm. daily, in three or four divided doses, is the treatment of choice in most cases. Isoniazid, 300 mg. daily and streptomycin 1.0 Gm. twice a week is almost as effective, but this combination has the disadvantage of risking the simultaneous development of bacterial resistance to both of our most effective drugs. Streptomycin, 1.0 Gm. twice a week, and PAS, 12 Gm. daily, is somewhat less effective than either of the other two combinations, especially for patients with far advanced disease and large cavities. Patients who do not improve on streptomycin and PAS after a few months may benefit by a change to isoniazid and PAS. However, treatment regimens may be dictated by what the patient can tolerate, so selection of drugs should be individualized. The physician will not go far wrong with a combination of any two of the three drugs, isoniazid, streptomycin and PAS.

Miliary tuberculosis should always be treated

The Author

● Dr. Humphrey, Columbus, is Superintendent and Medical Director of Benjamin Franklin Hospital, Columbus.

*This is the first of a series of articles on chest diseases sponsored by the Ohio Trudeau Society, medical section of the Ohio Tuberculosis and Health Association.

with a regimen which includes isoniazid. Most physicians use triple drug therapy in this condition—daily isoniazid, streptomycin, and PAS initially. If the response is good, after six weeks or two months the streptomycin may be discontinued, or decreased to a twice weekly schedule.

EXTRAPULMONARY TUBERCULOSIS

Current practice in **renal tuberculosis** is to use triple drug therapy, isoniazid, streptomycin, and PAS concurrently. The combination of isoniazid and PAS has not been tried in enough cases of renal tuberculosis to allow proper evaluation of results. Drug therapy has now obviated the need for nephrectomy in most instances.

Tuberculosis of bone responds well to any regimen containing isoniazid. Some surgeons prefer triple drug therapy.

Tuberculous lymphadenitis does not usually show any dramatic change under drug therapy. However, the drugs should be used for their value in preventing complications and further spread of the disease.

Tuberculous meningitis may be treated with initial triple drug therapy in the same manner as miliary tuberculosis, with elimination of the streptomycin after improvement occurs.

DURATION OF DRUG THERAPY

Chemotherapy for tuberculosis should be continued *without interruption* for two years in most cases. An early minimal case showing almost complete resolution by x-ray may possibly do well on one to one and a half years of drug treatment. The extensive chronic fibroid with cavitary lesion should be treated for more than two years, perhaps indefinitely, even though the sputum may have become negative.

SUMMARY

The average case of previously untreated tuberculosis can be controlled with our available drugs when these are combined with other forms of therapy such as rest, collapse and resectional surgery. Two drugs should be given concurrently, preferably isoniazid and PAS in most cases. Drug therapy should be continued for one and a half to two years without interruption, or longer when indicated.

Desensitization Experiments Relating to Bee Stings

Well-controlled experiments have been carried out by Benson and others in which tests were made with pure bee venom, extracts of the pure bee stinger, and extracts from the bee body, both with and without the sting and poison mechanism. It was shown that extracts made from the whole bee body are more economical and more effective in the preparation of testing and desensitizing material.—John T. Brunn, M. D., Meridian, Idaho: *Northwest Medicine*, 56:55, January, 1957.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Glenoid—Now specifically meaning the socket of the shoulder joint, this word comes from the Greek word "glenoeide," meaning "like a socket or cavity" and it was used by the ancient Greco-Roman physicians to designate any shallow cavity or socket. Galen applied the term to any shallow ball and socket joint. The Greek word "glenoeide" has a peculiar origin and is composed of the Greek words "glene," meaning "the pupil of the eye, or a mirror," plus "eidos," meaning "like, or form." Whether the term was applied to these joints because their surface is covered with a glistening cartilage which gives a mirror-like appearance or because it reminded the ancients of the manner in which the pupil and the whole eye was set into its socket is not clear.

Gracilis—A Latin word meaning "slender, or thin" which was descriptively applied to a long slender muscle on the medial aspect of the thigh and which helps to flex and cross the legs.

Graham Cracker—Sylvester Graham, an American physician who lived from 1794 to 1851, was an advocate of temperance and food reform. He introduced and popularized the use of unbolted wheaten flour, which became known as Graham flour. From this flour, bread, biscuits and crackers were made and the dietetic practice of eating of these substances became known as Grahamism.

Gullet—This term designating the esophagus of an animal came into English via the French word "goulet," which in turn is derived from the Latin word "gula," or throat.

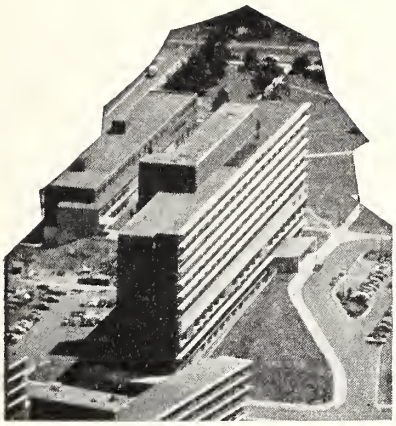
Sallow—Coming from the Anglo-Saxon word "salu," or discolored, this term now designates a pale sickly color tinged with yellow as, for example, a sallow skin.

Salve—A word of doubtful origin which may be derived from the Anglo-Saxon word "sealf," or ointment. There are a number of related words such as the Gothic "salbon" and the German "salbe." However, some authorities believe that the word is derived from the Latin word "salvus," meaning "whole and sound." Thus, a "salve" is something that helps save you and makes you whole and sound.

Sanatorium—Literally meaning "a place for healing," this term is derived from the Latin words "sanare,"—"to heal" plus the suffix "orium," meaning "a place or thing."

Scala—A Latin term literally meaning "a ladder or stairway," which comes from the Latin word "scandere," meaning "to climb." The scala tympani and the scala vestibuli were so named because of their resemblance in structure to a circular staircase.

—HARRY WAIN, M. D., Mansfield, Ohio.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Ralph J. Johansmann, M. D., President

Presented by Perry R. Ayres, M. D., and Emmerich von Haam, M. D Edited by Dr. von Haam

PRESENTATION OF CASE

THIS 40 year old white male entered University Hospital with a chief complaint of "heart trouble and a cold." Fifteen years ago he had been told by an Army doctor that he had a heart murmur but was accepted for military service. He had been working as a bulldozer operator until one and a half months before admission, when he contracted a cold which led to a persistent cough. He was first treated with penicillin by a local doctor and was finally admitted to another hospital, where he received treatment for his cough. During the past one and a half months he noted in addition to his cough a weight loss of 10 pounds, a bluish discoloration of his lips and face, swelling of his feet and of his face, shortness of breath and nocturnal dyspnea.

The past history revealed a partial gastric resection for ulcer six years ago, and a thyroidectomy for toxic goiter five years ago. There was no known history of rheumatic fever or symptoms thereof. A chest film taken several months ago was reported to show an enlarged heart. There was a family history of peptic ulcer and tuberculosis.

PHYSICAL EXAMINATION

The patient was found to be in moderately acute distress with hyperpnea, minimal cyanosis of the fingernails and some anxiety. He had nonproductive coughing spells every four to five minutes. His blood pressure was 120/60 in both arms, his pulse was 78 to 120, his respirations 28. The skin was cyanotic. He exhibited the scars from his thyroidectomy and abdominal operation.

The pupils were round, regular and equal and reacted to light and accommodation. The right ear drum showed an old perforation. The pharynx was moderately injected. Palpation of the neck revealed some fullness over the area of the thyroid. The chest showed equal expansion and was clear to percussion and auscultation; no wheezes or rales could be heard.

Examination of the heart showed the point of maximum impulse to be in the fifth intercostal space in the anterior axillary line, with a marked thrust. There was marked distention of the veins of his face, neck and shoulders. On auscultation one observer heard a Grade III systolic murmur and a Grade II diastolic murmur over the apex. At the base of the heart a Grade III murmur and no second sound were heard; this murmur was transmitted to the neck. The distal pulses were equal bilaterally. Another observer found a regular sinus rhythm with occasional premature systoles; the point of maximum impulse was in the same location. There was also a Grade III systolic and a Grade III diastolic murmur at the aorta. It was thought that the aortic murmur might be transmitted from the apical murmur or possibly vice versa.

The liver was enlarged 5 fingerbreadths beneath the costal margin and was very tender, especially during the coughing spells. The spleen was not palpable. His neurological examination showed no abnormalities.

LABORATORY STUDIES

On admission his red blood count was 5.7 million, his hemoglobin 15.7 Gm., the white blood count 7,500 with a normal differential count; the hematocrit was 53; his sedimentation rate corrected, 10 (Wintrobe). The antistreptolysin titer of the blood was 100 units and C-reactive protein was 2 plus. Throat cultures showed normal flora. Kolmer and VDRL tests were nonreactive. The urine examination was entirely normal, the specific gravity 1.023. The blood urea nitrogen was 26 mg. Bromsulphalein test showed a 10 per cent retention. The serum electrolytes were:

Submitted December 21, 1956.

sodium 132, potassium 5.1, chlorides 94 mEq. Prothrombin time was 39.5 per cent.

His white blood count rose later to 22,500 with 86 per cent neutrophils, his prothrombin time dropped to 12 per cent and his blood urea nitrogen rose to 37 mg. The electrocardiogram showed a first degree A-V block, ventricular premature beats and an intraventricular conduction defect with delayed QRS wave. The impression was left ventricular hypertrophy and myocardial changes (some of which might have been due to digitalis) and incomplete left branch block.

Chest x-ray showed bilateral cardiac enlargement with marked pulmonary hyperemia and a suggestive small amount of pleural fluid in the right base. There was a questionable calcification of the mitral valve area. A barium swallow showed a marked dilatation of the left atrium with displacement of the esophagus.

HOSPITAL COURSE

The patient was started on a course of diuretics with ammonium chloride and mercury, to which he did not respond too well. He was also digitalized with digoxin® and was given penicillin prophylactically. He received codeine intramuscularly for his cough. Five hundred cubic centimeters of blood were withdrawn by phlebotomy, following which the patient began to breathe somewhat easier but still did not have any diuresis. On the fifth day his temperature spiked to 100 but returned to normal the next day. Intravenous diuretics were successful but the patient began to vomit, which was considered as evidence of a digitalis intoxication.

On the seventh day the patient developed left pleuritic chest pain, a few flecks of blood in his sputum, tenderness over the left lateral chest and was put on anticoagulants. On the tenth day the patient developed diffuse abdominal pain and no bowel sounds were heard. The neck veins became markedly congested and soon thereafter respirations ceased and the patient died.

CLINICAL DISCUSSION

DR. PERRY AYRES: We are dealing here with a 40 year old white man who we know had valvular heart disease of some sort but who had no past history of rheumatic fever or lues. He already had his heart murmur many years ago when he was inducted into the Army, and his cardiac enlargement was present at the time he was treated for his thyrotoxicosis. However, the surgeons failed to hear any murmurs at this time. He was finally admitted with a persistent and very troublesome cough which did not yield to penicillin and which was associated with dyspnea, cyanosis and edema. Now his heart was definitely enlarged, he had a rapid pulse, normal blood pressure and a variety of heart murmurs were audible.

The laboratory tests offered little aid in making the diagnosis, although his white blood count rose markedly while the blood urea nitrogen increased slightly during his hospital stay. His hospital course was characterized by unremitting heart failure. He did not respond well to treatment of bed rest, oxygen, digitalis and diuretics. He had no fever except for a few days. He was treated with phlebotomy and that was of little avail. He finally developed pleuritic chest pain, bloody sputum and diffuse abdominal pain and died on the tenth day of his hospital stay.

It seems obvious that the patient was suffering from valvular heart disease, and I think on the basis of the murmurs described that we can exclude luetic heart disease. In the first place he had no history of lues, his serology was negative, and he had none of the other stigmata of tertiary lues. His heart murmurs seemed to originate in both the aortic and mitral areas, which again is not characteristic of lues. There is also nothing to lead us to believe that this was a case of congenital heart disease.

RHEUMATIC HEART

So we are left with rheumatic heart disease, which I think this man had in spite of the fact that he did not have the history of rheumatic fever. The next question is which valve was predominantly involved and was mostly responsible for his heart failure? That is an important question, because the fate of people with rheumatic heart disease is considerably different when the mitral valve is mostly involved than when the aortic valve is predominantly affected.

Patients with aortic valve disease who go into heart failure very often go progressively downhill and are seldom brought out of failure. Quite the contrary is true in patients with mitral valve disease. Here the patient who is threatened by heart failure often improves remarkably with the correct treatment and can compensate again and again until he finally develops irreversible failure. Therefore we have reason to believe that the rather rapidly progressive heart failure in our patient would suggest aortic valve disease, and from his pulse pressure I would suggest that he suffered from aortic stenosis. If the observation of an aortic diastolic murmur was correct, we could say that he probably also had some aortic insufficiency, but I don't think that was of great functional significance.

I am also certain that his mitral valve was also involved since he had definite mitral murmurs and since his x-ray showed the presence of calcium in the mitral valve area. From the x-ray picture we are also safe in concluding that he had left ventricular, right ventricular and left atrial enlargement. I don't know of any valvular disease that will produce this other than rheumatic heart disease, and I think on that basis and after analysis of his murmurs that this man had rheumatic heart disease with mitral stenosis

and insufficiency, aortic stenosis and probably some degree of aortic insufficiency.

Now why did he go into heart failure? About four years prior to his death he had a normal-sized heart and in those four years his heart enlarged some 35 per cent, which is quite a significant enlargement. Now in a patient with valvular heart disease who says he had a cold and has not done well since then, one of the first things we think about is subacute bacterial endocarditis, and we must consider it in the differential diagnosis, although there are several facts which rule this out fairly conclusively. The first and most obvious one is that his blood cultures were negative. To be sure, blood cultures can be sterile in the presence of active endocardial infection. Some organisms responsible for bacterial endocarditis are exceedingly difficult to grow, such as Brucella, and I have seen one case with Histoplasma endocarditis in which no positive cultures could be obtained. So organisms of that sort can be missed, but by and large, repeated blood cultures will eventually show an organism in this condition.

THE BLOOD

But more important seems the fact that his white blood count and his sedimentation rate were normal on admission and that he had no fever, no splenomegaly, no anemia and no hematuria. While any one of them could be absent in the presence of bacterial endocarditis, I do not think that this diagnosis should be made when all of them are absent.

The patient stated that he had had an infection for about a month and since then had gone downhill with his heart disease. This makes us think about the possible presence of active rheumatic heart disease. In support of such a diagnosis I would like to offer the following observations: First, the patient had a normal-sized heart four years ago and died in heart failure from valvular heart disease. That is not the rule with inactive rheumatic heart disease. Certainly they can die after having had no previous symptoms of failure for any length of time, but to die four years after having had a normal-sized heart is difficult to understand.

Ordinarily, in cases of mitral or aortic valve disease, the individual compensates for the increased burden of the heart by dilatation and hypertrophy of the ventricles, which can be easily recognized in the x-ray picture. However, his heart became enlarged after he supposedly caught cold. The cold may or may not have been the precipitating episode that resulted in acute rheumatic myocarditis, but I like to think that it was. I am postulating that his so-called "cold" was really a streptococcus infection and that he developed acute rheumatic fever without arthralgia, which is fairly common in persons of this age group.

Certainly I don't think that any one here would doubt that rheumatic myocarditis can occur at age 40, especially in patients who have suffered previously from rheumatic fever. So I feel that this man had an infection early in December which led to the development of acute rheumatic fever with rheumatic myocarditis and possibly reactivated his endocarditis, and that he failed partly on the mechanical basis of the valvular lesions—stenosis and insufficiency—but also partly because he had a sick myocardium that was not able to carry the burden any longer.

Rheumatic myocarditis is a fairly common contributing factor to heart failure in rheumatic heart disease among younger people. Certainly, of the patients who go into heart failure prior to the age of 30, nearly every one has a significant rheumatic myocarditis. That is especially true of the cases with predominant involvement of the mitral valve and to a lesser degree in patients with a wide aortic insufficiency. So I think that our patient suffered from rheumatic heart disease with active myocarditis and the chronic valve lesions. Even his borderline antistreptolycin titer, his borderline C-reactive protein and his normal sedimentation rate don't rule it out. I have seen people who developed and lost diastolic murmurs under observation in whom I could demonstrate no evidence of active rheumatic fever. I realize, however, that these observations speak against my diagnosis of active rheumatic fever.

HEMOPTYSIS

A few days before death he suddenly developed chest pain and hemoptysis, which I think we can explain on the basis of a pulmonary embolus. Pulmonary emboli are very common in people with heart failure, and pulmonary embolism is a very common cause of death in people dying of heart failure regardless of the etiology. Some pathologists have said that pulmonary infarction cannot occur unless the lungs are previously hyperemic. Certainly this man must have had congested lungs. He must have deposited a clot in his pulmonary artery either from his right atrium, which was very likely distended in the presence of failure, or from a peripheral vein, and I would have no exact idea as to the source of his embolus, and this caused pulmonary infarction two or three days prior to his death.

On the day of death he developed diffuse abdominal pain. His abdomen was not described as especially distended, but no bowel sounds were heard by one observer who listened. Abdominal pain and paralytic ileus will develop in persons with heart disease for a number of reasons. Of course hepatic congestion can cause abdominal pain, but he had that type of abdominal pain before and this was apparently something different. Infarction of any viscus within the abdominal cavity can lead to abdominal pain with or without back pain, and the picture of paralytic ileus. It is unusual for people to die abruptly

as a result of infarcts, and frankly I can't think of a single viscus within the abdomen which when infarcted will cause sudden death.

People may eventually die from mesenteric embolism, but they usually live for a few days provided they survive the shock of the initial embolus. This man apparently lived for at least a few hours, and it makes one wonder whether or not this final episode had anything to do with his death. I am inclined to believe that he simply died of heart failure after he suffered an infarct of some abdominal viscus, most likely the bowel but possibly also the kidney or spleen.

My final diagnosis therefore is chronic rheumatic heart disease with stenosis and insufficiency of the mitral valve, stenosis and some degree of insufficiency of the aortic valve; active rheumatic myocarditis; recent pulmonary infarction; and infarction within the abdominal cavity, probably mesenteric. Since he was in congestive heart failure he will show pulmonary edema and most likely some pleural effusion with peripheral edema. He may very well have some associated bronchopneumona, because often people with heart failure will have pneumonia without fever. His terminal leukocytosis would be evidence in favor of this.

GENERAL CLINICAL DISCUSSION

DR. VON HAAM: Dr. Ayres, as you know, we have our students participate in the CPC and I would like you to discuss their diagnoses briefly before we discuss the autopsy findings.

DR. AYRES: Certainly I am glad to commend the 95 per cent who made the diagnosis of rheumatic heart disease with mitral stenosis and aortic insufficiency, although for the reasons I have previously given I don't think the pertinent lesion in the arotic valve was insufficiency. Pulmonary infarction was diagnosed by 85 per cent and this shows a great deal of clinical wisdom. Thirty-five per cent made the diagnosis of polycythemia, which I cannot argue with. His hemoglobin and red count were certainly elevated. Seventy per cent made a diagnosis of mesenteric thrombosis; I think they mean a mesenteric embolus, which seems very wise.

Fifteen per cent diagnosed superior venacaval syndrome due to carcinoma of the lung, venous thrombosis or substernal goiter. It is a diagnosis which I could not consider seriously. Some diagnosed a cor pulmonale, and I have no idea what their basis for such diagnosis is in a man who had no history of chronic pulmonary disease. Twenty per cent made the diagnosis of subacute bacterial endocarditis and I don't believe that this was present for the reasons I have given previously.

A few made the diagnosis of perforated peptic ulcer, and, by golly, I didn't even think of that. But perforated peptic ulcer could very well have been the terminal event in this man, who had a resection for peptic ulcer six years ago.

MEDICAL STUDENT: What do you consider the source for his mesenteric embolism?

DR. AYRES: A distended left atrium. A patient does not have to be fibrillating to form thrombi in the atrium, particularly if it is dilated. Furthermore, it is conceivable that he had developed thrombosis in veins draining the area of pulmonary infarction and that this was the source of his mesenteric embolus.

MEDICAL STUDENT: I would like to offer a diagnosis of hemopericardium with tamponade because of his low prothrombin.

DR. AYRES: This may certainly be possible, and since I think that he had myocarditis he may well have also had pericarditis. However, a spontaneous hemopericardium is caused almost exclusively by a dissecting aneurysm of the aorta or spontaneous rupture of a myocardial infarct, and I don't think that significant quantities of blood would accumulate in the pericardial sac from any other reason.

CLINICAL DIAGNOSIS

1. Chronic valvular heart disease with predominantly mitral insufficiency and aortic stenosis.
2. Active rheumatic myocarditis.
3. Pulmonary infarction.
4. Bilateral hydrothorax.
5. Mesenteric infarction.
6. Terminal bronchopneumonia.
7. Anasarca.

PATHOLOGICAL DIAGNOSIS

1. Rheumatic heart disease with:
   a. mitral insufficiency;
   b. aortic stenosis;
   c. rheumatic myocarditis;
   d. congestive failure.
2. Pulmonary infarction.
3. Bilateral hydrothorax.

PATHOLOGICAL DISCUSSION

DR. VON HAAM: I selected this case because, as Dr. Ayres has pointed out, it is rather unusual in these days of modern therapy that a man in the best years of his life, who apparently never had a history of rheumatic heart disease except for this vague Army story, dies of rapidly developing heart failure. Most of the rheumatic patients remember their first attack of rheumatic fever when they were children or adolescents, but in this case heart failure came on quickly and without any preliminary story of typical rheumatic fever. This is the reason why Dr. Ayres suspected rheumatic myocarditis. He also chose a combination of mitral insufficiency and aortic stenosis rather than the more common mitral stenosis and aortic insufficiency.

The body was that of a well-developed and well-nourished white male. There was marked cyanosis of the ear lobes, lips and nailbeds. Each

pleural cavity contained approximately 750 cc. of clear fluid. The liver was enlarged and the peritoneal cavity contained about 300 cc. of clear fluid. The heart was enlarged and weighed 710 Gm., and there was a definite left ventricular hypertrophy.

The mitral valve showed definite anatomical evidence of insufficiency with retraction of the free edges and shortening of the tendons. We felt that the insufficiency of the valve was more pronounced than the stenosis of the ostium. In contrast, the aortic valve showed a marked stenosis of the ostium. In contrast, the aortic valve showed a marked stenosis of the ostium with marked calcification of the leaflets. So Dr. Ayres' prediction was correct and anatomically we have before us aortic stenosis and mitral insufficiency.

HEART SIZE

The right ventricle measured only 3 mm. in thickness and no cor pulmonale was present. The lungs were very heavy, weighing 700 Gm. each, and showed severe edema and two large recent infarcts, one in either lung. The obstructed vessels were small and I feel that this was more likely due to thrombosis than to embolism. If the heart is failing and the blood does not flow rapidly, I would say there is a more likely possibility of thrombosis by stasis rather than of embolism. There also was no clue as to a possible source of an embolus, although of course we might well have overlooked it. The spleen was enlarged, 300 Gm., and congested. The liver showed typical nutmeg design. The difference between a nutmeg liver and a cardiac cirrhosis is that the nutmeg liver represents acute or subacute congestion while the cardiac cirrhosis signifies a definitely chronic stage. Only a very slowly failing heart can produce a cardiac cirrhosis.

The small intestine showed a hemorrhagic discoloration of many loops with petechiae and edema. This definitely would agree with the idea of an early thrombosis. However, an inspection of the mesenteric vessels revealed nothing unusual. I think the diagnosis of an impending or very early mesenteric vein thrombosis is unquestionably indicated. The fact that the tissue was so edematous would suggest a decreased blood drainage with anoxic damage to the regional capillaries.

MICROSCOPIC EXAMINATION

Sections through the heart showed severe perivascular fibrosis indicative of inactive rheumatic myocarditis. While no typical Aschoff lesions were found, we did find a cellular infiltrate composed of some active monocytes, which would suggest the possibility of active inflammation. I think that the myocardial lesion is definitely not as old and inactive as the valvular lesions. Multiple sections through the valve showed no more evidence of activity but were compatible with healed rheumatic heart disease.

Sections through the lungs showed a very massive recent infarct which caused alveolar and bronchial hemorrhage. Many vessels were thrombosed but no particular large thrombus could be recognized. The liver showed a rather acute congestion, indicating that his right heart failure was more recent in nature. Sections through the other organs were not remarkable. The kidney did not show the glomerulonephritis we may expect in a case of rheumatic heart disease.

In summary, we have here a case of uncomplicated rheumatic heart disease with a complete lack of a typical history. I think Dr. Ayres' idea that this fellow had a revival of his rheumatic myocarditis is an excellent one and hits the point, because it gives us the explanation why he died at such an early age with little evidence of severe chronic valvular lesions.

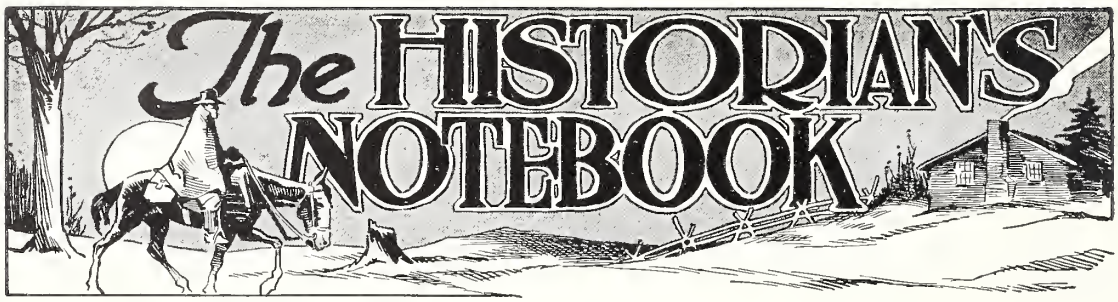
Bronchitis and Emphysema

Therapy [of emphysema] should certainly take into consideration the treatment of asthma if it is present. If bronchitis is the underlying cause, as it so frequently is, it should be vigorously treated. We should get the patient to avoid other irritants as well as tobacco. We believe mild physical exercise in order to keep the muscles toned up and the general condition of the body good is desirable, but at the same time we feel that the patient should avoid the degree of exercise that causes severe dyspnea. The so-called emphysema belts have frequently been advocated, but they are uncomfortable and rarely of any help.

Climate is important also for the patient with emphysema but once again it should be pointed out that this is an individual affair and what suits one will not necessarily agree with another. In general, these patients should live at altitudes of no more than 3,000 feet in a temperate zone, preferably rather dry.

Pneumoperitoneum has been advocated by some in an effort to raise the diaphragms and make for better diaphragmatic excursions. We have had only limited experience with this but have not been particularly favorably impressed. We do believe that breathing exercises are quite helpful and we use these routinely.

We also think that aerosol therapy is helpful, in the form of isuprel® and alevaire® in combination. Occasionally these are used with hand atomizers but in general the power pumps such as put out by the DeVilbiss Company, or tanks of compressed air or oxygen are preferable. In the past few years intermittent positive pressure breathing, such as obtained by either the Bennett or M. S. A. valves have proven beneficial and helpful.—E. E. Meneffee, Jr., M. D., Durham, N. C.: *Virginia M. Monthly*, 84:53, Feb.,1957.



Freudian Dream Interpretation Two Thousand Years Before Freud

Historical and Other Aspects of Dream Interpretation

MAX SEROG, M. D.

PART I

THE present attitude towards dream and dream interpretation is based mostly on Freud's ideas. Freud, the creator of psychoanalysis, employed the psychoanalytic method in psychotherapy and, afterwards he constructed the psychoanalytic theory to give a rational account of his psychotherapeutic results.

FREUD'S DREAM THEORY

Freud's dream theory is but the application of his psychoanalytic theory to the dream. It starts from the theoretical assumptions of psychoanalysis, not, as it should, from the dream itself and unbiased observation of the dream phenomenology; yes, important and significant features of the dream are neglected by Freud, if they don't fit into his dream theory.

Freud's psychoanalytic theory, on which his dream theory is based, is an artificial construction, built upon undue generalization and simplification, objectionable from logical, psychological and methodological viewpoints.

Additional objections must be raised against Freud's dream theory. There, as everywhere in his theory, the unconscious plays the leading role. The unconscious acts in the dream as censor and allows to pass into the dream only harmless material. All objectionable thought material is suppressed or transformed in such a way that it becomes fit to be presented in the dream. Through its censure the unconscious turns the latent into the manifest dream.

Hardly anyone will dispute that there are unconscious and subconscious functions and tendencies. But there is not and cannot be "The" unconscious of Freud's theory which acts and behaves in the dream like a human being. The unconscious of Freud is an anthropomorphic idea; it is a personification of functions. But whether we believe in mythic demons who govern the dream or in a mystic unconscious which reigns in the dream, any personification of functions is incompatible with our rational thinking.

Still more important is another objection against Freud's dream concept. The role of censoring, which Freud ascribes to the unconscious in the dream, means controlling and selecting. But to control and to select are functions of our co-ordinated intentional thinking, and just this kind of thinking is suspended in the dream. The dream is a state of mental disintegration. In this state the power to control and to select has ceased to function.

FREUD'S DREAM PHENOMENA

However, Freud is not only the creator of a speculative, objectionable dream theory, he is also the discoverer of dream phenomena, like replacement and condensation, which exist and can be confirmed by observation. These dream phenomena occur in the dream frequently, although not as a fixed rule, as Freud contends for the sake of his theory. The dream has significant

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The Author

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dynamisms, but it has no fixed rules. Nothing is more unpredictable than the dream.

In replacement the whole may be replaced by a part of it. Sometimes there is a replacement of emotional values in the dream; highly affective ideas appear as insignificant and vice versa.

Allusions and the double meaning of words play also a role in the dream dynamism.

Condensation occurs frequently in the dream formation. Several persons appear condensed into one person. The same condensation may happen with different places, yes, with different occurrings. Often parts of words appear condensed into one word, and its single parts, as well as the whole, have a particular meaning. Frequently through condensation of two different words a new, really not existing word (neologism) results. Such new formation of words in the dream may appear senseless at the first glance, but when understood, it may furnish some key to the mental attitude of the dreamer.

A significant example was a patient, treated by me years ago, who dreamt of the peculiar name "Ortilde." There is no name like this, and the patient had never heard of this name. But in everyone familiar with the music dramas of Richard Wagner, this odd name will evoke Ortrud from *Lohengrin* and Brunhilde from the *Ring of the Nibelungs.* The patient's associations confirmed that in this dream his marital conflicts were mirrored in the mood of Wagnerian dramatic situations. The antagonists here, the depraved, intriguant woman (Ortrud) and the heroic, but powerless wife (Brunhilde) were condensed into one person.

The dream phenomena observed by Freud rest on facts. However, these facts necessitate in no way Freud's dream theory. Better and simpler than through Freud's dream theory, his dream phenomena can be understood through the dream thinking which is predominantly primitive thinking. The phenomenon of condensation is found not only in the dream, but everywhere where primitive thinking prevails, in primitive tribes, in small children, in art production, in schizophrenics. (Serog)

The dream phenomena, like the phenomenon of condensation may point the way to the psychic understanding of an individual dream. They often are useful in the dream interpretation, as apparent from the dream just mentioned.

Although the dream is the product of a process of mental disintegration, dream interpretation is possible because even in the mental disintegration of the dream the dissociated mental fragments still carry the imprints of their emotional origin. In the dream the power of volition, of intentional co-ordinated thinking, of concentration and attention have ceased to function. Only emotionality persists unimpaired in its true character and dominates the dream uninhibited.

Emotional trends are essential parts of the complex phenomena which we call our character and our personality. So the dream and its interpretation becomes an important way for the understanding of character and personality. The dream is an uncontrolled emotional expression. Like other uncontrolled emotional expressions, it may reveal emotional tendencies which we cover up when awake, for the benefit of the intentions and purposes of our daily life.

Dream interpretation means to understand the psychic motivation which created the dream. Such psychic understanding is not a logical approach or a scientific procedure. It is an immediate interpretation through understanding empathy. It is a total emotional experience, similar to the emotional experience in the artistic approach.

Dream interpretation can be done adequately only from the individual dream, not from the rules of a theory. Freud's attempt to approach dream interpretation scientifically by causal explanation leads to pseudo-science. His inadequate approach results in far-fetched and distorted dream interpretations. For the purpose of its interpretation the dream has to be approached from its psychic side as a psychic phenomenon, understandable in its psychic motivations and psychic connections.

The dream, of course, can be approached also with the intention of its causal explanation. This is the rational-logical, the scientific approach. It is an approach from another side, with other means and for another purpose. It was done as early as a century ago when during sleep artificial stimuli were applied, and the dream reaction noted (Maury), when the duration of dreams was determined and the relationship between the state and depth of sleep and the occurrence of dreams was studied. It also was done through experiments with drugs.

Drugs, which cause dream states were known for thousands of years, and we know some of their specific effects (e. g. visual hallucinations of very small objects in dream states after cocaine intoxication). Because of the great developments of biological chemistry in recent years, we may hope for much progress in this field. However, this procedure of explaining causally is something else than the approach of psychic understanding.

Freud did not differentiate clearly between the two. Confusing cause and motivation, he arrived at the impossible conclusions of his psychoanalytic theory and his dream concept. However, Freud envisioned the psychotherapeutic opportunities of dream interpretation.

Freud's discovery of certain dream phenomena was not entirely new. In 1861 Karl Scherner, professor of philosophy at the University of Breslau, gave in his book, *The Life of the Dream*, a fine and thorough presentation of the dream phenomenology. Scherner, as many before him, emphasized the role of sexuality in the dream, but like Freud he exaggerated this role. Both inter-

preted everything in the dream sexually, so the dream interpretations of both are often of a striking similarity.

But the knowledge of Freud's dream phenomena goes far back to ancient times. As early as 2,000 years ago we find in the writings of Plutarch, the famous writer of ancient biographies, reports about dream interpretations which show that dream phenomena like condensation were known to the ancient dream interpreters, and were used by them in the technique of dream interpretation in a simliar way as today. Significant in this respect are dreams of Alexander the Great and their interpretations at his time.

DREAMS OF ALEXANDER THE GREAT

During the siege of Tyrus, Alexander the Great had a dream, which Plutarch reports as follows:

> "Alexander dreamt he saw a satyr mocking him at a distance, and, when he endeavored to catch him, he still escaped from him till at last with much perseverance and running about after him, he got him into his power. The soothsayers, *making two words of satyros** assured him that Tyrus should be his own."

The dream interpreters evidently recognized the double meaning of the word "saturos" as a revealing clue for the dream's interpretation. They knew that "satyros" in the dream was several things: It was a real satyr "mocking him at a distance." But Sa-Tyros was also two words and meant: "Thine shall be Tyrus." Tyrus, that was the city which was so close nearby, and yet, which, like the satyr in the dream, slipped away when he was going to catch it. Sa-Tyros, seen as two words and meaning, "Thine shall be Tyrus," reflected, as the dream interpreters apparently well understood, Alexander's firm conviction that in spite of his initial failures, the final victory would be his.

Alexander's determination and his idea: "It will not be an easy victory, but it will be a certain victory," is expressed once more in the dream. He gets "Sa Tyros" in his power "running after him at last with much perseverance."

During the siege of Tyrus, Alexander had other dreams pointing to the same interpretation. Alexander, recognizing the difficulties of his strategic situation, was about to withdraw his army when in a dream he saw a satyr dancing in triumph. Dream interpreters, when asked for the meaning of his dream, told him he would conquer Tyrus: Alexander ordered a vigorous attack and Tyrus was conquered.

The dream interpreters had well understood the meaning of Alexander's dream.

When a general sees difficulties in a military operation and is going to abandon it, the withdrawal of his army can result from two entirely different mental attitudes. Either he considers and evaluates difficulties to justify his lack of determination, he really does not want to attack; or he is determined and eager to attack, but recognizing his unfavorable tactical situation, he is doubtful if he should turn his determination into action against so many odds.

Alexander's dream, which expresses hope and depicts triumph, proved that his idea to withdraw his army was not born from lack of determined will power. His dream reveals his eagerness to attack. It shows his determined will for victory which guarantees victory. The close relationship which exists between determined intention and successful execution justifies the saying that hopes and dreams tend to become true.

Probably the ancient dream interpreters did not base their interpretations just upon one dream. Neither do we do that today, for we know that we often need several dreams to get a comprehensive picture of the dreamer's personality. Sometimes one dream may shed light upon the interpretation of another one.

We also know that the same dream, dreamt repeatedly, is of special significance and therefore requires special attention. Such dreams often have to be the starting point in the dream interpretation. The insight into the significance of frequently repeated dreams is as old as the Bible.

(To be concluded in April issue)

*The italics are mine. (Serog)
In the Dryden translation, corrected and revised by A. H. Clough, there is on page 189 the following footnote:
"Satyros or Saturos—a satyr.
"Sa Turos—Thine shall be Tyre."

Morgan County Medical Society—1840

The Morgan County Medical Society was organized in 1840 and Dr. Charles Robertson was the first president. Following the formation of the society, there would be a membership of 30 to 40 doctors; now there are four* practicing medical doctors in the county.

A daughter of Dr. Robertson, the late Mrs. Dessie Barrows, of California, relates this experience of Dr. Robertson:

When the first bridge was being built across the Muskingum at McConnelsville, a group of boys were playing on the timbers, piled along the bank. A large timber rolled down and caught one of the Cochran boys, then residing on Kennebec hill.

The limb was so crushed, at first it seemed it would have to be amputated but Dr. Robertson had a unique plan of his own for the treatment. He had a bed placed under an apple tree at the Cochran home, near a well with very cold water. It was arranged so the limb of the boy would have running water over the injury at all times. Mrs. Barrows states that the doctor had excellent results with this treatment; that, later, she danced with the young man and one could not tell he had ever been injured.—*McConnelsville, (Ohio) Morgan County Herald,* December 6, 1956.

*Four physicians reside in McConnelsville—eight in Morgan County.

Annual Meeting Guest Speakers . . .

Scientific Program in Columbus, May 14-16. Will Include Out-of-State Physicians; Key Laymen Will Speak on Legal-Economic Questions.

PLANNERS for the 1957 Annual Meeting in Columbus, May 14-16, have reached near and far to bring Ohio physicians an outstanding and well-rounded program. Features will include, in addition to scientific talks with appeal for physicians in all branches of practice, a panel discussion on "The Doctor and the Law" and a discussion on "The Malpractice Problem and What's Being Done to Cope With It"; a movie and panel discussion on "The Medical Witness"; also a practical presentation by experts on estate planning and investments.

This year's meeting will be centrally located in Columbus. The program will be presented in the new Veterans Memorial Building. This under-one-roof session will add much to the unity of the meeting.

In addition to the meeting of the State Association, a number of specialty societies have planned their own programs in connection with the Annual Meeting. Most of these specialty organizations will meet on Monday, May 13.

OUT-OF-STATE GUEST SPEAKERS FOR THE SCIENTIFIC PROGRAM



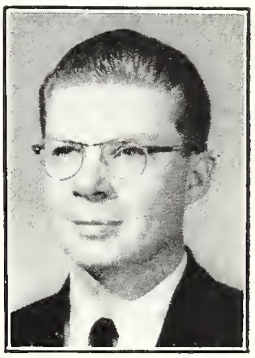
G. J. CURRY, M. D.
Flint, Mich.



M. J. NICHOLSON, M. D.
Boston



OGLESBY PAUL, M. D.
Chicago



J. A. PRITCHARD, M. D.
Dallas

George J. Curry, M. D., Flint, Mich.; chief of the Section for the Surgery of Trauma, Hurley Hospital, and consultant on the same subject, McLaren Hospital, Flint, and consultant to the Genesee County Hospital, also in Flint. Dr. Curry, a well-known authority on the surgery of trauma, is a Fellow of the American Association for Surgery of Trauma and the American College of Surgeons; also a member of the Board of Governors of the latter organization; is a past-president of the Michigan Chapter of the ACS and chairman of the Regional Committees on Trauma, which is a subcommittee of the ACS Committee on Trauma.

Dr. Curry will discuss and show a sound, color movie on the subject **Transportation and Immediate Care of the Injured** during the **Symposium on Management of Automobile Injuries**, a General Session, Tuesday afternoon, May 14.



Wm. H. SWEET, M. D.
Boston



LEO J. WADE, M. D.
New York City

B. Dixon Holland, M. D., Chicago, is secretary of the AMA Council on Industrial Health. He is a graduate of the University of Texas Medical Branch, has a master's degree in public health from Johns Hopkins and is a diplomate of the American Board of Public Health. Dr. Holland served with the U. S. Army Medical Corps as Colonel, and was later director of the Army Federal Civilian Employees' Health Service and

as chief of preventive medicine at the Aberdeen Proving Grounds in Maryland.

He is scheduled to speak on the subject of **Professional Relations** as it pertains to **The Physician and the Smaller Plant**, as part of a panel discussion before the Section on Industrial Medicine on Tuesday morning.

John O. Moore, New York City, is research associate in the Department of Public Health and Preventive Medicine, Cornell University Medical College, and director of automotive crash injury research at that institution. Mr. Moore had considerable high echelon experience during and after the war survival techniques, safety design and crash injury prevention research with the Armed Forces. He is a member of the Commission on Accidental Trauma, Armed Forces Epidemiological Board, Department of Defense; member of the Subcommittee on Highway Users, Highway Traffic Standards Board, American Standards Association; advisor to the Committee on Trauma, American College of Surgeons; member of the National Committee on Uniform Traffic Laws and Ordinances, National Safety Council, and holds numerous other appointments.

He will speak on the subject **Crash Injury Prevention** as part of the **Symposium on Management of Automobile Injuries**, a General Session on Tuesday afternoon.

Morris J. Nicholson, M. D., Boston, is a member of the Department of Anesthesiology, Lahey Clinic; anesthesiologist on the staff of the New England Deaconess Hospital and associate anesthesiologist for the New England Baptist Hospital. He is a member of the American Society of Anesthesiologists and the International Anesthesiology Research Society.

He will speak on the subject **Hypotension and Hypothermia from the Standpoint of an Anesthesiologist** during the joint session of the Sections on Anesthesiology and Neurological Surgery, Wednesday morning; and again on Wednesday afternoon before the General Session he will discuss **The Problem of Pain: Diagnosis and Treatment.**

Oglesby Paul, M. D., Chicago, is clinical associate professor of medicine, University of Illinois College of Medicine, and chief of the Cardiac Clinic of Presbyterian Hospital, Chicago.

He will speak twice on Wednesday. Before the joint session of the Section on General Practice and Section on Internal Medicine, Wednesday morning, he will discuss **Recognition and Treatment of Cardiac Emergencies**; and on Wednesday afternoon he will address a General Session on the subject **Mistakes in the Handling of Congestive Heart Failure.**

Jack A. Pritchard, M. D., Dallas, Texas, is chairman of the Department of Obstetrics and Gynecology, University of Texas Southwestern Medical School, and chief of the Department of Obstetrics and Gynecology of Parkland Memorial Hospital. He is a graduate of Western Reserve University School of Medicine; a member of the American College of Obstetrics and Gynecology; the Central Society for Clinical Research, and other professional organizations.

Dr. Pritchard will discuss **The Use of Hypotensive Drugs in Toxemia** before the Section on Obstetrics and Gynecology on Tuesday morning.

William H. Sweet, M. D., Boston, Mass., associate clinical professor of surgery in the Harvard University Medical School and former lecturer in neurosurgery at Tufts College Medical School; associate visiting neurosurgeon, Massachusetts General Hospital; member of the American Academy of Neurology; Fellow of the American College of Surgeons, and active in many other professional organizations.

Dr. Sweet will speak twice during the Annual Meeting—(1) before the joint meeting of the Section on Anesthesiology and the Section on Neurological Surgery, Wednesday morning on **Hypotension and Hypothermia from the Standpoint of a Neurosurgeon**; and (2) before the General Session on Wednesday afternoon on the subject **The Surgical Treatment of Parkinson's Disease.**

Leo J. Wade, M. D., New York City, is medical director of the Esso Standard Oil Company and associate clinical professor of occupational medicine, New York University Postgraduate Medical School. He is a Fellow of the American College of Physicians; Fellow of the Industrial Medical Association; Diplomate of the American Board of Internal Medicine and Diplomate in occupational medicine, American Board of Preventive Medicine.

Dr. Wade will discuss **Industrial Medicine: 1957**, before the Section on Industrial Medicine on Tuesday morning.

Henry L. Williams, M. D., Rochester, Minn., is professor of otolaryngology at the Mayo Foundation Graduate School and head of the Section on Otology and Rhinology at the Mayo Clinic. He is a member of the American Laryngological Association, the American Academy of Ophthalmology and Otolaryngology, The American Laryngological, Rhinological and Otological Society, and other professional groups. He was a lieutenant commander in the U. S. Navy Medical Corps.

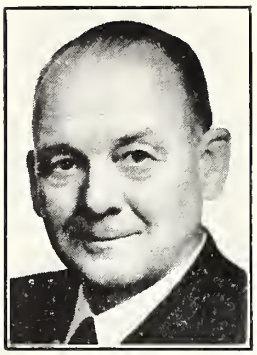
Dr. Williams will speak on **The Medical and Surgical Management of Bell's Palsy** before the Section on Otorhinolaryngology on Tuesday morning.

The foregoing speakers and subjects comprise only part of a well-rounded scientific program planned for the Annual Meeting, and designed to bring Ohio physicians practical postgraduate courses related to everyday practice. Watch for the complete Program in the April issue.

WILL DISCUSS LEGAL AND ECONOMIC SUBJECTS



W. T. HACKETT
Columbus



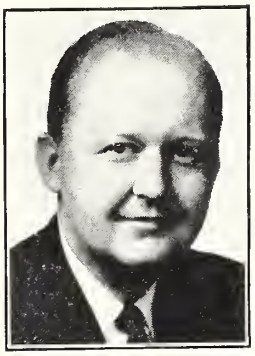
L. O. HOOPER
New York City



Wm. J. McAULIFFE
Chicago



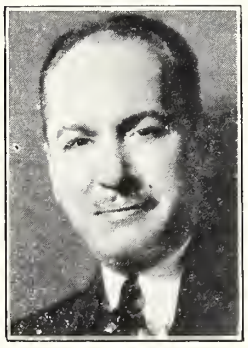
EARL F. MORRIS
Columbus



C. J. STETLER
Chicago



W. E. STICHTER
Toledo



H. E. LeFEVER, M. D.



J. D. WILSON, M. D.

When should you consult a lawyer? What are some of the legal problems confronting all physicians? How should a doctor conduct himself in court? How often in your practice are you exposing yourself to a malpractice suit? If you should become permanently disabled tomorrow, how would you, your partner or your family fare? Are your investments secure yet profitable?

To bring practical and authentic answers on many such problems, the Association has invited key persons in the legal and economic field to present the respective subjects, "The Doctor and the Law," "The Malpractice Problem and What's Being Done To Cope With It," "The Medical Witness," "Advice to Physicians on Estate Planning" and "Advice to Physicians on Investments."

Here are the speakers on these subjects:

R. Brooke Alloway, Columbus, is a practicing attorney who has had wide experience in handling plaintiffs' cases. His background includes experience as bailiff and law clerk in the Common Pleas Court, special agent for the FBI, corporation attorney and assistant attorney general. Mr. Alloway is a member of the Ohio State and American Bar Associations, and the National Association of Claimants' Compensation Attorneys of which he was former Ohio executive secretary. He is currently chairman of the Ohio Bar's Committee on Workmen's Compensation.

Mr. Alloway will participate in a panel discussion on **The Medical Witness** on Wednesday afternoon.

W. T. Hackett, Columbus, is vice-president and trust officer for the Huntington National Bank. His principal duties are to make estate analyses for the bank's clientele. Mr. Hackett is, therefore, in a position to give physicians down-to-facts advice on this ever vital subject. Since 1948 in his present position, Mr. Hackett formerly headed his own estate analysis firm and later merged with the Haydock & Company of Cincinnati. Still earlier he was with Heman T. Powers & Company and T. L. Chapman & Company, of Chicago—all top firms in the field.

Mr. Hackett will present **Advice to Physicians on Estate Planning** on Thursday morning before the General Session. All physicians—especially those who have not had personal counsel on estate planning—should hear this timely talk.

Lucien O. Hooper, New York City, is chief analyst for W. E. Hutton & Co. and is one of the nation's best known financial writers. He has been president of the New York Society of Security Analysts, Inc., and of the National Federation of Financial Analysts Societies. He has been writing about the stock market for more than 30 years and is in a top position to speak with authority on his subject.

That subject is **Advice to Physicians on Invest-**

ments and will be discussed on Thursday morning at the General Session.

William J. McAuliffe, Jr., Chicago, is an attorney and member of the Law Department of the AMA. He has been trial attorney in the Anti-Trust Division of the Department of Justice and trial attorney for the Civil Aeronautics Board in Washington, D. C.

Mr. McAuliffe will discuss **The Malpractice Problem and What's Being Done To Cope With It,** on Thursday afternoon during the General Session.

Earl F. Morris, Columbus, is a member of the law firm of Wright, Harlor, Purpus, Morris and Arnold, and is current president of the Ohio State Bar Association. A graduate of the Harvard Law School, he recently received an honorary degree of Doctor of Laws from Wittenberg College, his Alma Mater. He was chairman of the Judicial Reform Committee of the State Bar, is a member of the American College of Trial Lawyers and member of the House of Delegates of the American Bar Association. He is a moderator of the Columbus Town Meeting, a well-known television program.

Mr. Morris will participate in the panel discussion **The Doctor and the Law** on Tuesday afternoon.

C. Joseph Stetler, Chicago, is director of the Law Department of the American Medical Association; and before his present assignment was secretary to The AMA Council on National Defense and secretary to the AMA Committee on Legislation. He is in a strategic position to view and understand the legal phases of medical practice and organization. Mr. Stetler's background includes several high Washington appointments and service during World War II. He received his law degree in 1938.

Mr. Stetler will particiate in **The Doctor and the Law** panel discussion on Tuesday afternoon. Also Mr. Stetler will moderate a panel discussion which follows the film **The Medical Witness.**

Harry E. LeFever, M. D., and **Judson D. Wilson,** M. D., both of Columbus, responded to an invitation to participate in panel discussion following presentation of the AMA film, **The Medical Witness.** They will present the subject from the standpoint of practicing physicians. Dr. LeFever is a neurosurgeon, professor of neurosurgery at Ohio State University and a diplomate of the American Board of Neurosurgery and the American Board of Neurology. Dr. Wilson is a practicing orthopedic surgeon, acting chairman of the Department of Surgery at Ohio State and diplomate of the American Board of Orthopedic Surgery.

Wayne E. Stichter, Toledo, a practicing lawyer in Ohio since 1924 and member of a prominent Toledo law partnership, has had unlimited experience in legal practice, professional counsel and organization work. His accomplishments as briefed in **Who's Who in America** are too numerous to recount here. Suffice it to say that with his many years as legal counsel for the Ohio State Medical Association and his other contacts with medicolegal affairs, he has attained a highly professional and personal interest in the doctors' legal problems.

Mr. Stichter will moderate the panel discussion, **The Doctor and the Law** on Tuesday afternoon, and will participate in the panel discussion following the showing of the film **The Medical Witness.**

Alexander Aitken, M. D., is medical director of the Liberty Mutual Life Insurance Company, Brookline, Mass. A graduate of Tufts College Medical School, 1928, he is a diplomate of the American Board of Orthopedic Surgery; member of the American Academy of Orthopedic Surgeons, International College of Surgeons, American Association for the Surgery of Trauma and Fellow of the American College of Surgeons; he is clinical professor of orthopedic surgery at Tufts College.

Dr. Aitken will participate in the **Symposium on Management of Automobile Injuries,** a General Session on Tuesday afternoon, stressing particularly **Rehabilitation of the Injured.**

Resolutions Should Be Sent To Columbus Office Now

Delegates or members and County Medical Societies having resolutions for introduction into the House of Delegates at the 1957 meeting of the Ohio State Medical Association May 14, 15 and 16, Columbus, should, if possible, transmit such resolutions as soon as possible to the Columbus Office so the proposed resolutions can be published in the April issue of *The Ohio State Medical Journal* and copies sent in advance to all members of the House of Delegates.

The above is a recommendation contained in the By-Laws of the Association.

Compliance with the recommendation will help to expedite work of the House of Delegates and provide delegates with advance information as to what questions may be brought before the house for action.

Cincinnati Sanitarium Changes Its Name To The Emerson A. North Hospital

One of the oldest private psychiatric hospitals. The Cincinnati Sanitarium has changed its name to The Emerson A. North Hospital in honor of Dr. North, late professor of psychiatry at the University of Cincinnati, former resident at the hospital which bears his name, and active in other psychiatric work in Cincinnati. The hospital is located at 5642 Hamilton Avenue in Cincinnati. Elliott Otte is president and Dr. Owen C. Clark, medical director.

Polio Immunization . . .

Official Statement Adopted by The Council, February 3, Urging All County Medical Societies To Join in Local Educational Programs

A SPECIAL meeting of The Council of the Ohio State Medical Association was held in the Columbus office on Sunday, February 3, for the purpose of reviewing the present situation in Ohio with regard to immunization against polio. All members of The Council, except the following, were present: Dr. Frank H. Mayfield, Cincinnati; Dr. James R. Jarvis, Van Wert; Dr. Carl A. Gustafson, Akron; and Dr. E. H. Artman, Chillicothe. Others attending the meeting, by invitation, were the following: Dr. Carl A. Wilzbach, Cincinnati, chairman of the Committee on Education; Dr. Ralph E. Dwork, Columbus, State Director of Health; and Mr. Earl Wright, Administrative Assistant, Ohio Department of Health.

President Meiling asked Dr. Dwork and Mr. Wright to provide The Council with information as to the official status of polio immunization in Ohio, as revealed from statistics of the Ohio Department of Health. Many questions were asked by members of The Council, and answers were given by Dr. Dwork and Mr. Wright.

FACTS AND STATISTICS

The following information was presented by Dr. Dwork and Mr. Wright during their presentations and in answer to specific questions:

It is estimated that in Ohio there are approximately 3,000,000 persons between 0 and 19 years inclusive and there are approximately 225,000 pregnant women in any 12 months. According to available records approximately 2,558,925 cc. of polio vaccine have been sold by manufacturing pharmaceutical firms to Ohio physicians or druggists, between August, 1955, and January 1, 1957.

Likewise, approximately 752,016 cc. were distributed by the National Foundation for Infantile Paralysis for Ohio children.

SOME U. S. FUNDS LEFT

The Ohio Department of Health has purchased with Federal funds approximately 1,628,000 cc. of vaccine and distributed them to local health departments. The Ohio Department of Health as of now has enough Federal money on hand (roughly $800,000) to purchase approximately 1,212,000 cc. of vaccine for use between now and June 30, 1957, when the Federal law expires.

There is no way of knowing exactly how many in the various age groups have actually been immunized as there is no way of securing accurate figures on the number of persons immunized by physicians with commercial vaccine. However, the department estimates that about 60 per cent of the 5-9 age group have had two shots and that about 10 per cent of the 10 and above age group had received two shots as of November 15, 1956.

WANT IT TO BE ROUTINE

The Ohio Department of Health is proposing that after July, 1957, the purchase and distribution of polio vaccine should be handled in the same manner as the department now purchases and distributes smallpox vaccine, diphtheria, tetanus and whooping cough vaccine, etc., to the local health departments of the state, leaving it to the local health departments to decide the method of distribution to physicians and how the vaccine is used in their respective areas. The General Assembly is being asked to include funds for this purpose in the department's appropriation for the biennium starting July 1, 1957.

The department noted a considerable increase in requests for vaccine in the past 60 days, and interprets it as an awakening interest in polio immunity. Further, if the increase in requests continues at the same level, the department estimates that it will be out of vaccine by the latter part of April. The USPHS has informed the Ohio Department of Health that it is not requesting funds to buy more vaccine.

REPORT ON CHICAGO MEETING

Dr. Wilzbach, and Mr. Page of the OSMA staff, reported on a meeting held in Chicago on January 26, sponsored by the American Medical Association. The meeting was attended by representatives of all state medical societies. The purpose of the meeting was to stimulate renewed interest in educational programs to awaken the public to the need for immediate polio immunization. Dr. Wilzbach and Mr. Page reviewed statements made at the meeting by national figures, and analyzed some of the information presented from various states and communities on polio programs which have been under way in those areas.

REPORTS ON COUNTIES

Members of The Council then were asked to report on polio educational and polio immunization programs in the counties of their district.

Reports were given by all Councilors in attendance and reference was made to reports re-

ceived in writing or by telephone from those Councilors who were unable to attend the meeting.

The Council then went into executive session to discuss the situation generally.

PREVIOUS ACTIONS RE-AFFIRMED

It was felt that actions and statements of policy previously made by The Council should be reaffirmed, especially actions and statements recorded in the April, 1955, issue of *The Journal*, page 371, and June, 1955, issue of *The Journal*, page 596. By official vote, such actions were reaffirmed.

In line with these expressions of sentiment and based on the information received and reviewed at the current meeting, The Council, by official action, adopted the following statement of policy:

OFFICIAL STATEMENT ADOPTED

"The Council of the Ohio State Medical Association has noted with a great deal of satisfaction that the medical profession, through the County Medical Societies, is taking a leading part in the present state-wide program to stimulate renewed interest on the part of the people of Ohio in immunization against polio.

"We urge County Medical Societies to continue the educational program on this subject, in cooperation with public health and school officials and with various civic and community groups. Medical leadership and counsel are essential to such educational programs. The medical profession can do much to convince the public of the importance of polio immunization and win public support for community-wide action.

"Physicians are able at this time to advise their patients and the community generally that:

"1. The Salk polio vaccine is considered both safe and effective in preventing paralytic polio.

"2. Every person—child or adult—under 40 years of age, should be immunized.

"3. Polio vaccine is now available to everyone.

"4. Those who have received one or two injections should make every possible effort to secure a third injection before the peak of the polio season in the late Summer and early Fall.

"5. Those who have not received at least one injection should request the initial injection promptly.

"Development of an adequate immunization program in each community continues to be the joint responsibility of the local medical profession and the local public health officials. The combined efforts of all community forces will be required to make the program effective.

"Although their objective will be the same, local programs will have to vary (1) to meet the particular needs of the community; (2) to use to the best advantage existing local facilities and resources; (3) to comply with methods and techniques which the local medical profession deems the best to meet local needs.

"At all times during the polio immunization programs here in Ohio, communities have been encouraged by the Ohio State Medical Association to use methods best suited to local conditions. There can be no stereotyped pattern.

"Immunization against polio should rapidly become a part of the preventive medical services which families will request, and receive, routinely from their personal physician.

"Now is the time for concerted action in all parts of Ohio to eliminate, if possible, the backlog of persons under 40 years of age who have not received protective injections against polio."

The Executive Secretary was instructed to send to the president and secretary of each county medical society a copy of the statement and a memorandum compiling recommendations presented at the AMA meeting in Chicago, January 26, with regard to procedures which might be used for local educational programs on polio immunization. Also, he was instructed to release the statement of The Council to the press, radio and television for use on or after 12 noon, Tuesday, February 5.

There being no further business, The Council adjourned.

Attest: CHARLES S. NELSON,
Executive Secretary.

Mrs. Ireland, Mr. Minor Appointed To State Welfare Posts

Governor C. William O'Neill recently announced appointment of Mrs. R. L. Ireland, of Cleveland, as director of the Ohio Department of Public Welfare, and Mr. Richard C. Minor, Columbus and Worthington attorney, as assistant director.

Before assuming the post of State Welfare director, Mrs. Ireland was active in many welfare, civic, educational and charitable activities in Cleveland.

A veteran of World War II, Mr. Minor was admitted to the bar in 1952. In addition to his private law practice, he has for the past four years been assistant attorney general representing the Welfare Department and other state agencies. He has also had a background of probation work with the Franklin County Juvenile Court and Domestic Relations Court.

Mrs. Ireland succeeds Judge Henry J. Robinson as state director of welfare. Robert B. Canary formerly was assistant director in addition to his present duties as chief of the Division of Social Administration.

7,686 Students Enter Medical Schools

Medicine as a profession still has a strong appeal among young people. A recent report by the American Medical Association shows that 7,686 students, a record number, entered medical schools in the 1955-56 academic year. Of this number, 5,753, or 75 per cent, had four years of college education.

Ohio Representative Reports on AMA Mental Hygiene Conference

The Ohio State Medical Association was privileged to have an official representative at the recent Chicago conference on mental hygiene sponsored by the American Medical Association and known as the Third Annual Conference of Mental Health Representatives of State Medical Associations. He is Dr. Dwight M. Palmer, Columbus, chairman of the OSMA Sub-Committee on Mental Hygiene. Following is Dr. Palmer's report:

The meeting was concerned with the study and evaluation of four problems and the following brief statements represent the concensus of the participants as they appeared to the writer. It should be emphasized that the opinions expressed are not necessarily the official attitudes of the American Medical Association.

1. **Hypnosis.** This is a subject that has recently attracted much lay attention. The procedure has a limited place in medical therapy but its use should be under proper medical or dental auspices. The procedure should be taught under responsible medical guidance and its use for entertainment purposes should be discouraged. All those who use hypnosis should be aware of the possible dangers involved.

2. **Tranquilizing Drugs.** The widespread use of tranquilizing drugs has caused some concern. It is true that this usage has brought about a leveling process between psychiatry and medicine and this is very desirable. However, it was agreed that these drugs should not be considered in any sense as a "shortcut to happiness." It is too early to be definite about dependency needs and addiction to the tranquilizing drugs but such possibilities exist.

3. **Chronic Alcoholism.** The acceptance of alcoholism as a disease and the reception of alcoholic patients into general hospitals represents an advance in thinking concerning a problem that affects one out of 16 adults in the United States. The immediate medical care of the acute alcoholic state may well be carried out in a general hospital. This treatment should be followed by long term management in an attempt to bring about such changes in the patient's personality as to enable him to meet the problems of living without resorting to the misuse of alcohol. It has to be conceded that there are some patients who have no capacity for personality reorganization and growth, and the need for custodial centers for these patients is apparent.

4. **In-Patient Psychiatric Care of Children.** This is a form of medical treatment which has scarcely gotten under way in our country, although the needs are great. It is an expensive project and a large amount of public education is necessary before legislative bodies will feel impelled to appropriate the funds for such hospitals. This also represents an area of medical care where private gifts are greatly needed. There is great need for research in this area and for the correlation of the needs with causative mechanisms arising out of the present social disorder.

Ohio Congressmen Named To Important Committees

U. S. House of Representatives committees of importance to health and medical legislation in which Ohio representatives hold memberships during the 85th Congress are as follows:

Armed Services—William E. Hess (R), Cincinnati; **Appropriations**—Michael J. Kirwan (D), Youngstown, and Cliff Clevenger (R), Bryan; **Veterans Affairs**—William H. Ayres (R), Akron; **Ways and Means**—Thomas A. Jenkins (R), Ironton; **Government Operations**—Clarence J. Brown (R), Blanchester; **Interstate and Foreign Commerce**—Paul F. Schenck (R), Dayton; **Post Office and Civil Service**—David S. Dennison, Jr. (R), Warren.

Law-Medicine Center, Western Reserve, To Present Program on Heart

The Law-Medicine Center in Cleveland, a cooperative activity of Western Reserve University and the Cuyahoga County Coroner's office, will present a two-day Institute on "The Heart: A Law-Medicine Problem" on March 22-23. These full day sessions are designed to aid lawyers, doctors, claimsmen, personnel administrators, labor union officials who handle personal injury litigation, workmen's compensation, and rehabilitation matters involving heart and vascular system injury and disease.

With medical scientists and practitioners from Western Reserve University and The Cleveland Clinic as lecturers and discussion leaders the subject matter will include practical subjects ranging from physiology to placing the cardiac patient in industry.

Registration for the Institute can be made through Professor Oliver Schroeder, Jr., director, The Law-Medicine Center, Western Reserve University, Cleveland 6, Ohio. Tuition is $25.00. with information on nearby housing furnished on request. Dr. Samuel R. Gerber, Cuyahoga County Coroner, will serve as moderator.

Darley New AAMC Executive

Dr. Ward Darley, who recently resigned as the seventh president of the University of Colorado, is the new executive director of the Association of American Medical Colleges, which has its office in Evanston, Ill. Dr. Dean Smiley will continue to serve as secretary of the Association, a job he has held for the last nine years.



Mark These Dates

On Your Calendar . . . and . . .

Make Hotel Reservations Now

For the 1957 ANNUAL MEETING of the OHIO STATE MEDICAL ASSOCIATION. The place is COLUMBUS: the dates, MAY 14, 15 and 16, 1957.

Here is a list of leading downtown Columbus hotels and a hotel reservation blank for convenient mailing.

NAME AND LOCATION	SINGLE	DOUBLE	TWIN
NEIL HOUSE, 41 S. High St.	$ 6.00-11.00	$ 9.00-11.00	$11.00-14.00
DESHLER-HILTON HOTEL, W. Broad & N. High	$ 5.00-13.50	$11.00-18.50	$11.00-18.50
FORT HAYES HOTEL, 31 W. Spring St.		$ 9.00 up	$ 9.00 up
SENECA HOTEL, 361 E. Broad St.	$ 4.00- 7.00	$ 6.00- 9.00	$ 9.00-12.00
HOTEL SOUTHERN, S. High & E. Main Sts.		$ 8.00 up	$ 9.00 up
VIRGINIA HOTEL, Gay & Third Sts.	$ 7.00- 8.00	$10.00-12.00	$11.00-14.00

Persons who desire additional accommodations are advised to specify their needs to the hotel of choice.
(All Rates Subject to Change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager ..... Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 14, 15, 16, 1957, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....

☐ Twin Bed Room with Bath ☐ Other

Arriving May at A. M. P. M.

PLEASE VERIFY MY RESERVATION

Name .....

Address .....

.....

Data on Medicare . . .

Washington Office Gives Interpretation on Treatment of TB Patients, Drugs for Maternity Patients, Circumcision of Newborn, Use of Blood

THE Dependents' Medical Care Program (Medicare) is new and obviously from time to time interpretation of the law will be made as questions of procedure arise. Responsibility for such interpretation falls to the Office for Dependents' Medical Care (ODMC), which operates under Surgeon General, Department of the Army.

Following is information and guidance furnished by that office:

Treatment of Tuberculosis:

The question has been raised regarding the treatment of tuberculosis as to just what areas are included in Section 201(a)(2), Title II, P.L. 569—84th Congress.

Section 5, Para. 502, Joint Directive for Implementation of the Dependents' Medical Care Act, 18 Oct. 1956, specifically authorizes the following treatments.

a. Acute medical conditions, acute exacerbations of chronic diseases, and acute complications of chronic diseases.

b. Surgical Conditions—during hospitalization.

c. Contagious disease—during hospitalization.

d. Acute emergencies of any nature which are a threat to life, health, or well-being.

In accordance with these principles, the treatment of tuberculosis, when it is manifest as follows is **authorized** in civilian hospitals:

a. Tuberculosis, acute.

b. Tuberculosis when contagious.

c. Acute exacerbations or complications of chronic tuberculosis.

d. Cases requiring surgery.

Limitations: The following are **not authorized:**

a. A period of hospitalization in excess of 365 days for any one admission unless specially authorized.

b. Treatment in a hospital other than one which meets the following requirements.

Definition: "The word 'hospital' shall mean only an institution which is operated in accordance with the laws of the jurisdiction in which it is located pertaining to institutions identified as hospitals, is primarily engaged in providing diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of staff physicians or surgeons, and continuously provides 24-hour nursing service by registered graduate nurses. It shall specifically exclude any institution which is primarily a place of rest, a place for the aged, a place for the treatment of drug addiction or alcoholism, a nursing home, a convalescent home, or a facility operated by the Federal Government, or any agency thereof."

c. Domicilliary care or prolonged convalescence.

d. Treatment of an out-patient.

Medical Policy on Pediatric Care: In some localities a pediatrician sees the newborn infant in the hospital at birth and is responsible for its care during the remainder of the hospital stay. In those places where this is customary the same practice may be followed in the Dependents' Medical Care Program in the following manner:

a. First call, history, and necessary examination. Bill under hospital, home, or office.

b. Follow-up visits in hospital when warranted and as may be customary.

c. Visits after patient leaves the hospital, not to exceed a total of two during first 60 days.

If during the two post-hospital visits immunizations are given the cost of the immunizing agent and administration is allowable.

The above applies in the case of well babies.

Pediatric care for premature or ill babies during hospitalization is not restricted.

X-Ray Therapy: Radiotherapy normally performed without hospitalization is not a proper charge under the provisions of Public Law 569. In those instances, during a period of hospitalization when treatment by the use of x-ray, radium, or radioisotopes is prescribed such treatment may be continued or carried out on an outpatient status and properly charged as shown in the Schedule of Allowances.

Complete Obstetrical and Maternity Care: Obstetrical and maternity cases are excluded from the $75.00 limit for diagnostic tests and procedures prior to hospitalization, for the same bodily injury or surgical procedure for which hospitalized, and the $50.00 allowable for the same purpose after hospitalization.

Obstetrical and Maternity Care (Trimester Calculation):

The liability of the Government for obstetrical and maternity care commenced on 7 December 1956 and includes any care rendered on or after that date. The Schedule of Allowances specify fees for each trimester separately. In calculating the amount due when care for a part of a trimester is rendered, the compensation will be on a pro rata basis of the amount allowable in the fee schedule for that trimester. In counting the days for which payment is due on new patients, computation will be made from the first day the patient is seen to the end of the trimester. For patients terminating their care with the physician, the fee due will be computed from the first day

seen until the last day patient is under his care. If the patient was actually under care at the beginning of the trimester on or after December 7, 1956, the fee would then be computed from the beginning of the trimester until the last day patient is under the physician's care. In new patients reporting in early pregnancy to the physician, if the patient is seen in the first 60 days of the first trimester it can be assumed that complete care for that trimester has been furnished if the patient, in fact, is consulting a physician for the first time and if the patient remains under care of the same physician for the remainder of the trimester.

Furnishing of Drugs and Medicinals to Obstetrical and Maternity Patients:

The Joint Directive governing the implementation of the Dependents' Medical Care Program provides for complete maternity and obstetrical care. Therefore, drugs and medicinals required for the treatment of patients receiving maternity and obstetrical care may be furnished at Government expense. These items may be obtained by the patient from available stocks at a uniformed services pharmacy upon the prescription of the attending physician.

If the attending physician provides the patient receiving obstetrical and maternity care with these items, he will be entitled to reimbursement by the Government. As there is no provision in the program for the Government to make payments to a pharmacy, the physician should include the pharmacy bill for these items in the statement which he submits to the fiscal agent. In these instances, the physician will be expected to make payment to the pharmacy.

Circumcision of the Newborn:

The circumcision of the newborn infant prior to discharge from the hospital following delivery is considered "necessary or required infant care," and is chargeable on the statement covering obstetrical and maternity services. The readmission of the infant subsequent to the discharge of the Mother is considered a new admission and a separate billing from the hospital would be required. Physician's fee for the circumcision of the newborn infant on an out-patient basis is payable by the Government when performed during the two neonatal visits authorized within 60 days following delivery.

Procurement of Blood Under Medicare Program:

The cost of blood and the service charge for blood is an allowable benefit under the Dependents' Medical Care Program. However, it is intended that the Government will pay for the cost of blood only in those instances where the blood is not replaced on a gratuitous basis. Physicians providing care under the Medicare Program should urge relatives and friends of the patient to donate blood as required. This practice has been successfully employed in uniformed services medical facilities and is consistent with the practice in many communities in the United States.

In those instances where blood must be purchased, these purchases must be made by the hospital and included on its claim submitted under the program. There is no other way for payments to be made by the Government to a local blood bank as there are no provisions for making those payments in the Medicare contracts.

Certification of Attending Physician: The additional certification of the attending physician in Item 31 of DA Form 1863 is only required in the three cases for which blocks have been provided, that is: ☐ Care in Private Accommodations; ☐ Private-duty Nursing Care; or ☐ Consultants' Services. In respect to the last block, consultants' services, this is further limited to include only the medical or surgical consultant as determined necessary by the attending physician. The use of the term "consultant" as used in this instance does not include those physicians or dentists designated in Item 15 of DA Form 1863 (Radiologist, Pathologist, Anesthesiologist, Assistant to Surgeon, or Dentist).

Additional Certification Regarding Obstetrical and Maternity Care: That part of Section III, DA Form 1863, which is entitled "Additional Certification Required of Dependents Receiving Obstetrical and Maternity Care" does not apply to claims submitted by hospitals and nurses or to claims submitted by physicians who are not claiming payment for obstetrical and maternity care. This certificate is to be accomplished only on those forms submitted by physicians who are claiming payment for obstetrical and maternity care furnished under the Dependents' Medical Care Program.

Note: Ohio physicians are reminded that administrative and fiscal details of the Medicare Program are being handled in this state by Mutual of Omaha. It plans to send batches of Form 1863 to secretaries of County Medical Societies where they may be obtained. Completed forms should be sent to: Dependents Medical Care Department, Mutual of Omaha, Post Office Box 1298, Omaha, Nebraska.

Physicians Seeing Medicare Patients Please Note

A review of experiences of various states in the Medicare Program so far indicates that many forms have to be returned by the fiscal administrator to physicians for these main reasons: (1) Failure to submit signed Form 1863 in duplicate; (2) failure to secure signature of the dependent or the accompanying parent or guardian in Section Three of the form; (3) failure of physician to sign blanks and (4) failure of anesthetist to state length of time in administration of anesthetic.

What To Do With The Drug Addict . . .

Interpretation of Federal Law on Handling Addicts Reviewed; Some Sound Advice for Physicians Found in Statement Issued by the AMA

WITH a stronger narcotics law recently effective in Ohio, and a new and stiffer Federal narcotics control law, practicing physicians in the Buckeye State may find it of value to review Federal regulations pertaining to drug addiction.

Those regulations provide that issuance of a prescription to an addict or habitual user of narcotics "to keep him comfortable by maintaining his customary usage," and not in the course of professional treatment, is a violation of the law.

Further, the person issuing the prescription and the person filling it, both, may be penalized.

The regulation fixes responsibility for prescribing and dispensing narcotics both on the physician and the druggist.

MUST BE MEDICAL CASE

The physician may prescribe narcotics for habitual users only in the bona fide treatment of a medical case, and only in amounts necessary to meet the needs of the particular case.

The government's own interpretation of the regulations dealing with addiction is found in Pamphlet No. 56, reading in part as follows:

"The responsibility for the proper prescribing and dispensing of narcotic drugs under the Harrison Narcotic Law rests upon the physician in charge in any given case . . . [and] corresponding responsibility rests upon the druggist who fills the prescription to determine, in good faith, that the prescription was issued in the course of professional practice and not for the purpose of gratifying addiction . . . The good faith of the physician and the bona fides of his treatment in a given case will be established by the facts and circumstances of the case and the consensus of medical opinion with regard thereto, based upon the experience of the medical profession in cases of similar nature. Physicians will be expected to exercise such care in every case where narcotic usage is indicated, that the patient under treatment shall receive no quantity of narcotic drug greater than that sufficient for bona fide medical needs in order that there may be no surplus available for possible diversion by the patient to illicit use . . . Mere addiction alone is not regarded or recognized as an incurable disease. It is well established that the ordinary case of addiction yields to proper treatment and that addicts can remain permanently cured when drug taking is stopped and they are otherwise physically restored to health and strengthened in will power."

Some excellent advice on the question—"What To Do With A Drug Addict"—is found in a statement issued by the Council on Pharmacy and Chemistry of the AMA. Following are suggestions for the physician based on that statement:

TWO IMPORTANT PRINCIPLES

Two principles to be remembered in treating the addiction question are: (1) Ambulatory treatment of addiction should not be attempted as institutional treatment always is required, and (2) Narcotic drugs should never be given to an addict for self-administration.

While the physician is not legally required to report addiction cases to Federal officials, the Bureau of Narcotics welcomes voluntary reporting by the physician.

After tentative diagnosis, the physician should seek confirmation by consultation and should advise institutional treatment.

Should the addict reject such advice, the physician ethically may refuse any further participation in the case.

If the patient indicates wilingness to enter an institution, efforts should be taken immediately to admit him to the nearest, most available facility.

SHOULD CHECK CAREFULLY

Physicians also should guard against false intention of the addict to enter an institution, and should resist his demands for narcotics other than administration of opiates for physical disease.

For example, if the physician prescribes morphine for an addict's asthma, his waiting room soon will be filled with addicts suffering with self-diagnosed "asthma."

Once the addict has proof that he is to enter an institution, the problem is reduced to one of patient management. The addict's word as proof of intent should not be accepted.

If there is a waiting period for admission to a proper institution, the addict may be admitted to a general hospital where narcotics can be administered under careful supervision.

DOCTOR SHOULD ADMINISTER

In any event, the physician himself should administer any drugs the patient receives, and under no circumstances should give the addict a prescription. A special record of narcotics administered should be maintained, and only his immediate need should be satisfied.

The type and dosage of the drug should remain unknown to the addict and, if at all possible, all other drug sources should be circumvented.

Physicians prescribing narcotics for incurable,

fatal, painful disease should be personally attending the patient. Before narcotics are used, the diagnosis should be confirmed by consultation and all other pain-relieving methods should be exhausted.

Drugs, where possible, should be given orally rather than hypodermically, and should not be given directly to the patient for self-administration.

When a former addict becomes afflicted with a disease for which narcotics usually are prescribed (this situation may develop when a surgical operation is necessary), the doctor should treat the case as if there had never been an addiction since the former addict has lost his tolerance to narcotics.

Dosage should be prescribed in the same amounts and intervals as customary with persons who never were addicts.

VA Schedules Weekly Clinical Conferences in Cleveland

The Cleveland Regional Office of the Veterans Administration has announced a series of weekly clinical conferences which began in February and will run through May. Meetings are held in the Conference Room, 7th floor, Cuyahoga Building on Wednesdays beginning at 8:00 a. m.

The following subjects and speakers have been announced:

March 6—"Steroids"—Dr. R. T. Smith, Medical Research (Merck Sharp & Dohme).

March 13—"Cancer Education of the Laity"—Drs. R. E. Bowman and E. B. Wolf.

March 20—(1) "Recording of Ureteral Peristalsis Machine," (2) "A Kit for Spot Tests of Stone Analysis," (3) "Nephroscope and Kidney Grid"—Dr. H. R. Trattner.

March 27—"Newer Developments in Therapeutics"—Dr. W. Allan Wright, Chief Medical Director (Chas. Pfizer & Co., Inc.).

April 3—"Some Interesting X-Ray Cases"—Dr. R. M. Iseman.

April 10—"Clinical Pathological Conference"—Clinical Pathologist, Dr. Francis Bayless; Clinician, Dr. H. N. Roback.

April 17—"Prosthesis"—Roy Wing.

April 24—"Brainstorming"—Drs. H. S. Curtis and E. B. Wolf.

May 1—"Family Life Education"—Cleveland Regional Office Social Service Staff.

May 8—"Caries Control by Water Fluoridation"—Drs. T. J. Flaherty and F. H. Nealon.

May 15—"Pulmonary Disease" — Dr. D. H. Minnis.

May 22—"Hypothyroidism"—Dr. S. W. Kessler.

May 29—"Interesting X-Ray Cases in Cleveland Regional Office"—Dr. D. Magid.

The Tri-State Medical Association To Meet in Toledo, April 11

The Northern Tri-State Medical Association has laid its plans to hold the annual meeting on April 11 at the headquarters building of the Academy of Medicine of Toledo, 3101 Collingwood Blvd., Toledo. This announcement was made by Dr. D. G. Mason, secretary-treasurer, 416 East Maumee St., Angola, Indiana.

This will be a joint meeting with the Toledo Academy whose meeting date for the month has been changed to Thursday for the occasion. As usual this will be a one day meeting beginning at 8:50 a. m., with registration open at 8:00 a. m.

The Northern Tri-State Medical Association is composed of physicians of the neighboring areas of Ohio, Indiana and Michigan.

The program has been announced as follows:

Welcome. Dr. William J. Neal, Archbold, president, and Dr. Max Schnitker, president of Toledo and Lucas County Academy of Medicine.

Oral Hypoglycemic Agents. Dr. W. R. Kirtley, associate in medicine, Indiana University School of Medicine; director of Medical Research, Eli Lilly and Company.

Role of the Newer Drugs in the Treatment of Emotional and Mental Disturbances:
Dr. Nicholas P. Dallis, Toledo, moderator.
Dr. Ralph Patterson, professor of psychiatry, Ohio State Univ. College of Medicine, Superintendent Columbus Receiving Hospital and State Institute of Psychiatry.
Dr. Joseph Duty, Supt. Toledo State Hospital.
Dr. James Kenyon, Toledo Clinic, Toledo.

Routine X-Ray Examinations of Newborn Infants. Dr. James Boyd, Adrian, Mich., consulting radiologist, Bixby, Detwiler and Heller Hospitals.

Luncheon. Academy of Medicine.
A. Short Business Meeting.
B. **Life With Rex Morgan, M. D., and Judge Parker,** Dr. Nicholas P. Dallis, creator of Rex Morgan, M. D. and Judge Parker.

Everyday Problems in General Practice. Dr. A. R. Marsicano, Columbus, Ohio., chairman, publications Committee Staff, *Ohio G. P. News.*

Business Management in Medical Practice. Mr. Henry C. Black, professional management, Black and Skaggs Associates, Battle Creek, Michigan.

Evaluation of the Results of Surgery in the Treatment of Cancer: Dr. George Crile, Jr., Head of Department General Surgery, Cleveland Clinic.

Dr. Robert L. Faulkner, secretary of the American Board of Obstetrics and Gynecology, announced that the next scheduled examinations (April II) oral and clinical will be conducted at the Edgewater Beach Hotel, Chicago, May 16-25. Dr. Faulkner may be contacted at his office, 2105 Adelbert Rd., Cleveland 6.

Licenses Granted . . .

As a Result of December Examinations, 64 Graduates of Approved Medical Schools Are Issued Certificates To Practice in the State

RESULTS of the examinations conducted by the State Medical Board of Ohio on December 17-19, were considered by the Board at its meeting held on January 29. On the basis of the examinations, 64 graduates of schools of medicine have been authorized certificates to practice medicine and surgery in Ohio, Dr. H. M. Platter, secretary of the Board, announced. Also 28 graduates of osteopathic schools were authorized certificates to practice osteopathic medicine and surgery.

In the limited branches, certificates were issued to 1 chiropodist, 2 mechanotherapists, 12 chiropractors, 6 masseurs and 6 cosmetic therapists.

Highest grade in the examinations in medicine and surgery was made by Friedrich K. Urschler, Columbus, a graduate of the University of Graz, Austria, with an average of 90.3 per cent.

Second high grade of 89.4 per cent was made by Laimdota Dombrovskis, Brooklyn, N. Y., a graduate of the University of Latvia; and third high of 88.6 per cent went to Alan D. Dawson, Toledo, a graduate of the University of Michigan.

Following are the names of those licensed to practice medicine and surgery. (Home address is given in parentheses if the home address is different from place of residence at time of examination.)

GRADUATES OF U. S. AND CANADIAN SCHOOLS

Monroe S. Arnovitz, Cincinnati (Cleveland), University of Utah; Carl H. Bailey, Jr., Cleveland (Sharon, Pa.), Jefferson Medical College; Jack Lee Barga, Dayton (Versailles, Ohio), George Washington University; William E. Clendenning, Cleveland (Waynesburg, Pa.), Jefferson; Alan D. Dawson, Toledo, University of Michigan;

R. Newell Ford, Cincinnati (Farmington, Utah), Cornell; Norman R. Gevirtz, Cleveland (New York City), University of Chicago; Thomas R. Holland, Euclid (Morristown, N. J.), Columbia; James H. Johnson, Philadelphia, Pa. (Newark, Ohio), Jefferson; Richard S. Kaufman, Cleveland, Columbia; Leonard J. Kucharski, Cleveland, Marquette;

John C. Lampkin, Toledo (Saravac, Mich.), University of Michigan; Theodore J. Marshall, Akron (Elmhurst, Delaware), Jefferson; Joseph W. Samuels, Jr., Birmingham, Ala., Howard University; Geo. R. Skorey, Oak Ridge, Tenn., (Youngstown), University of Toronto, Canada; Paul B. Swinderman, Greentown, Northwestern;

Howard T. Wadstrom, Akron, Hahnemann Medical College; Sherwyn E. Warren, Columbus, Chicago Medical School; Bernard J. Woodley, Toledo, University of Michigan.

GRADUATES OF FOREIGN SCHOOLS

(Arranged alphabetically by country in which medical school of graduation is located.)

Argentina: University of Buenos Aires—Mario Tamburini, Pittsburgh, Pa.

Austria: University of Graz—Friedrich K. Urschler, Columbus.

University of Innsbruck—Fritz Hamm, Pueblo, Colorado (Regensburg, Germany); Samuel M. Mendlovic, New York City (Medzilaborce, Czech.); Konstancija Paprockaite, New York City (Brooklyn); Bertold Pembaur, Cincinnati.

Bulgaria: University of Sofia—Ganka K. Bendereva, Washington, D. C.

China: Aurora University of Shanghai—Joseph Liang, Flint, Mich., (Parkersburg, W. Va.).

National Central University of China—Yu Ru Yuan, Little Rock, Ark.

National Tung-Chi University — Ching-Chi Chem, Fort Polk, La.

Southeastern Medical College, Shanghai—William Chew.

Cuba: University of Havana—Oscar F. Gutierrez, Cleveland.

France: University of Paris—Alphonse Podrizki, Youngstown.

Germany: University of Berlin—Ismail F. D'Javid, New York City.

Frederick Wilhelm University—Lucia Trandafir, Cleveland.

University of Erlangen—Mary E. Doerr, Chattanooga, Tenn.; Roman M. Kysilewskyj, Newark, New Jersey.

University of Gottingen—Werner E. Donath, Cincinnati; Klaus L. Stemmer, Cincinnati.

University of Hamburg—Heinz Lord, Bridgeport, Conn.; Oscar Wilhelmy, Chicago.

University of Heidelberg—Hans R. Beutner, Chattanooga, Tenn.; Robert H. Jackson, Westlake; Laura E. Pollack, Ann Arbor, Mich. (Minersville, Pa.); Henrikas Solys, Chicago.

University of Munich—Roman C. Cherny, Fort Monroe, Va.; Samuel Cydulka, Cleveland; John E. Daffner, Cleveland (Munich, Germany); Isaac N. Gemelitzki, Columbus (Cleveland); Boris Kolb, Newark, N. J.

University of Munster, Westphalia—Pauls R. Z. Grube, Schenectady, N. Y.

Hungary: University of Budapest—Bela O. Duboczy, Syracuse, N. Y.

(Continued on Page 322)

Ireland: National University of Ireland—James B. Corbett, Ft. Knox, Ky.

Italy: University of Bologna—Herman Freireich, Brooklyn, N. Y.

University of Catania—Mario Milazzo, Oceanside, N. Y.

University of Messina—Francesco Paino, Cleveland.

University of Turin—David Finzi, Staten Island, N. Y. (New York City).

Latvia: University of Latvia—Laimdota Dombrovskis, Brooklyn, N. Y.

Lithuania: University of Kaunas—Viktoras Puskorius, Urbana, Ill. (East Cleveland).

Mexico: University of Guadalajara—Jose G. Ibanez, Passaic, N. J.

Peru: National University of San Marcos—Alberto A. Zavaleta, Cleveland.

Poland: University of Lemberg—Myron Saturski, Irvington, N. Y.

Spain: University of Madrid—Manuel Conde, Wellesley, Mass.

Switzerland: University of Geneva — Marie Pancner, Cleveland.

Ukraine: University of Kiev—Ivan Barchenko, Passaic, N. J.

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State Medical Board Makes Its Annual Report

The Ohio State Medical Board issued certificates to practice to 501 doctors of medicine, following examinations, during 1956, according to the Board's annual report for that year.

By endorsement, and without examination, the board issued certificates to practice to 319 doctors of medicine who had qualified previously in other states.

Fifty-eight osteopathic applicants were issued certificates to practice osteopathic medicine and surgery, following examination, and 13 applicants for osteopathic medicine and surgery certificates were qualified by endorsement. Limited practice certificates were awarded to 116 persons.

Of 280 cases in 62 counties investigated by the Board's inspectors, who made 2,685 calls, 31 were taken to court, 22 persons were convicted, five cases were dismissed and eight remained to be tried as of December 31. Fines assessed totalled $3,300, with $680 suspended, and 21 cases pending from former years were disposed of.

Death Rate Is Low Again

Excellent health conditions prevailed among the American people in 1956, according to the statisticians of the Metropolitan Life Insurance Company. A continued favorable health record is expected in 1957.

For 1956, the death rate in the United States is indicated as 9.3 per 1,000 population, or on a par with that for 1955. The year just ending is the ninth in succession to show a national death rate below 10 per 1,000 population.

Do You Know?...

Dr. Albert B. Sabin, University of Cincinnati College of Medicine and Children's Hospital Research Foundation, and his associates are continuing their experiment on a live polio vaccine with the aid of a $161,980 grant from the National Foundation for Infantile Paralysis.

* * *

A lectureship in honor of Dr. Torald Sollmann, dean emeritus of Western Reserve University School of Medicine, has been established by Nu Sigma Nu.

* * *

Doctors of tomorrow are showing a marked interest in the tranquilizing drugs. In the Schering Corporation contest the number of students who selected the subject "Recent Advances in the Biochemical Aspects and Treatment of Mental Disease" was almost double the number who selected the other two subjects, cardiology and eye disorders.

* * *

Dr. A. Ashley Weech, Cincinnati, was recipient of the 1956 Borden Award presented by the American Academy of Pediatrics. Dr. Weech is professor of pediatrics, University of Cincinnati, medical director of Children's Hospital in Cincinnati and director of the Children's Hospital Research Foundation.

* * *

Citizens of the area met in the Stone Creek school auditorium recently to honor Dr. O. C. Crawford on his 80th birthday.

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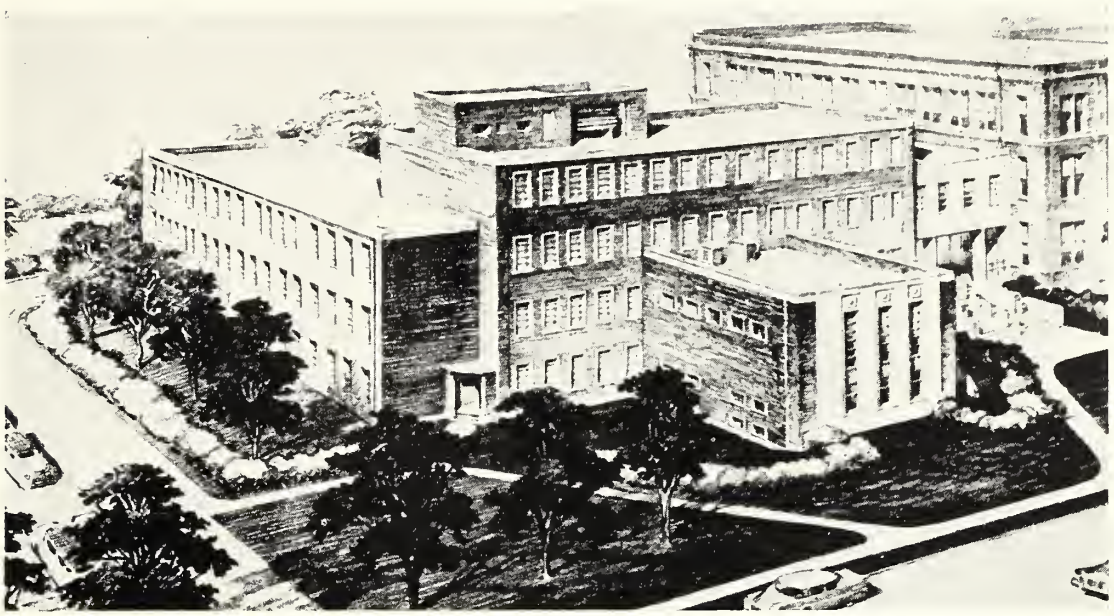
On June 12 the first annual Enrique E. Ecker Seminar in Experimental Pathology will be held in the amphitheater of the Institute of Pathology, Western Reserve University, at noon. Dr. Ecker, professor of immunology, will be honored at that time on the occasion of his formal retirement from the faculty. He will give the seminar on the subject of complement.

Most Medical Students Subject To Military Service

A recent report by the American Medical Association disclosed that 81.5 per cent of all male students enrolled in medical schools during the 1955-56 academic year were subject to military liability. The number cited as liable for service makes no allowance for physical disabilities and other factors that would render an unknown percentage ineligible for service.

In the 1955-56 year, male students with military liability constituted 81 per cent of the first year class, 82 per cent of the second year, 82.5 of the third year, and 80 per cent of the fourth year group.

Research Building for University of Cincinnati



This is an architect's sketch of the proposed University of Cincinnati College of Medicine research building to front on Eden Avenue west of General Hospital, shown partly at the right. Construction was made possible through a million dollar city bond issue approved in 1954 and a matching Federal grant of $865,688. The old building, designed for a student body of 240 is accommodating 360. With the addition, capacity will be increased to 400.

Regional Gastroenterology Program Scheduled in Grand Rapids

A regional meeting of the Central Region of the American College of Gastroenterology will be held in Grand Rapids, Mich., Sunday afternoon, March 17, Dr. Stanley S. Sidenberg, Cleveland, ACofG governor, announced. The Scientific Sessions will be at the Hotel Pantlind commencing at 1:45 p. m.

Participating in the program will be Drs. Joseph B. Kirsner, Chicago, Ill.; William Fuller, Grand Rapids, Mich.; Joseph Shaiken, Milwaukee, Wisconsin; C. Wilmer Wirts, Philadelphia, Pa.; Garnet Ault, Washington, D. C.; Don W. McLean, Detroit, Mich.; Frederick A. Coller, Ann Arbor, Michigan; Fred Hodges, Ann Arbor, Mich.; and C. Allen Payne, Grand Rapids, Mich.

There will be three individual papers and a panel discussion on "Gastrointestinal Bleeding" moderated by Dr. Coller with the speakers of the afternoon as the participants.

The Central Region which consists of the states of Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota and Wisconsin, will be represented at the meeting. A copy of the program may be obtained from the Secretary, American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

OSU Medical Alumni Reunion Scheduled April 27

Preliminary plans for Ohio State University's fourth annual Medical College Alumni reunion, scheduled for April 27 on the campus, were announced by Dr. Robert J. Murphy, 40 S. Third St., Columbus, general chairman.

The one-day event will include tours of the University Health Center, a joint faculty-alumni scientific program, election of officers of the Medical Alumni Association, and a luncheon highlighted by presentation of Alumni Achievement Awards.

Serving as chairmen of the class reunions are: 1912—Dr. William H. Miller; 1917—Dr. Fred E. Hall; 1922—Dr. Walter H. Hamilton; 1927—Dr. Robert M. Zollinger; 1932—Dr. Tom F. Lewis; 1937—Dr. Arthur G. James; 1942—Dr. Francis W. McCoy; 1947—Dr. Paul M. Hatfield; and 1952—Dr. Ernest W. Johnson; all of Columbus.

The general chairman of the reunion, Dr. Murphy is a graduate of the 1946 medical class and secretary of the Medical Alumni Association.

Other officers are: President—Dr. Paul A. Davis, Akron; president-elect—Dr. Morris S. Rosenblum, Youngstown; and treasurer—Mrs. Margaret R. Colburn, Columbus.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

CREEPING SOCIALISM IN SMALL CHUNKS

C. Joseph Stetler, director of the AMA Law Department, recently spoke on national medical legislation before the Texas State Medical Association. He closed with a bit of provocative information of interest to the profession.

It is the custom of the AMA Washington staff to visit all new congressmen at the beginning of a session. Carrying out their jobs, Dr. William J. Kennard and Paul Donelan stopped in to chat with Congressman Dingell of Michigan, who succeeded his late father—a man well known to the medical profession for many years.

As the AMA people entered, Congressman Dingell was busy cutting and pasting a new bill.

"You gentlemen won't like what I'm doing," he said, "because I'm getting ready to reintroduce a new version of the old Wagner-Murray-Dingell bill."

"The new bill," he added, "is going to be much smaller than the one introduced the last time." With that he held up a substantial number of pages and dropped them in the waste basket, saying "these items have already been enacted."

And with that, Mr. Stetler thanked his audience and sat down.

Unless something happens to change the trend, we're going to have most of the original Wagner-Murray-Dingell Bill in small chunks, but have it nevertheless.

TRY YELLING NOW TO YOUR LEGISLATORS

Writing in the *Ohio General Practice News*, Dr. R. C. Doan, president of the OAGP, commented as follows regarding Congress and Federal legislation:

"As physicians all that we have in our profession may be at stake in some of the legislation that is coming up in the near future. We must be willing and ready to give some of our time to protect one of the finest and greatest institutions in American life."

How true! The point applies equally as well to the Ohio General Assembly and state legislation. Do you know your county representative; your state senator? Have you tried to get acquainted with them; with your Congressman; your U. S. Senator?

Yelling bloody murder after a bill is passed and becomes a law won't do a bit of good. Yelling now—to your legislators—might do a whale of a lot of good. Try it once. You may be agreeably surprised.

ADMISSION STANDARDS ARE RE-EXAMINED

The Association of American Medical Colleges recently conducted a reappraisal of standards for selecting students for admission to medical training. The result was a special panel's suggestion that admission requirements undergo careful re-examination.

Increased competition for top quality students from other sciences and other fields for the good student prompted the action.

The special panel expressed the opinion that the student who does nothing but keep his nose buried in textbooks may not have the potential for becoming a good doctor. More potential may be found in the student whose grades are lower but who has a better over-all college record, including extracurricular activities.

It was found that the individual's MCAT rating provided a better barometer of his future as a physician.

In our opinion, it is good for the medical school admissions system, or for any other system, to be kept fluid and mobile through reappraisal.

Any program can hardly fulfill its purpose if it becomes a fixed thing, a matter of "doing it this way today because it was done that way yesterday."

Incidentally, a recent report by the American Medical Association shows that 13.6 per cent of the students who entered the nation's 76 approved four-year medical schools during the 1955-56 academic year had a "C" college grade average. Over a six-year period, 70.6 per cent of the entering students had a "B" average while, over the same period, only about 15.8 per cent of the entering classes had the enviable "A" average.

MINOR OF RESPONSIBLE AGE CAN GIVE CONSENT

Only nominal damages can be secured when a surgeon does elective surgery on a minor aged 18 years, according to an Ohio Supreme Court decision of December 18, 1956, says the *Columbus Academy of Medicine Bulletin*.

Moreover "nominal" actually means just that, according to the court, suggesting that $1 meets the definition.

In the case of Lacey v. Laird (166 O.S.) the defendant performed plastic surgery on an 18 year old girl's nose without securing parental consent. This is a technical assault, decided the majority of the court, but only nominal damages could be assessed where no actual loss was shown.

Judge Taft in writing the decision pointed out that this was only consistent with other rights

and liabilities of a grown minor, who is responsible for criminal acts from aged 14 onward, stating:

"Does any boy who kisses a girl under 21 with her consent but without the consent of her parents thereby expose himself to an action for assault and battery; and does every high school football player run the risk of assault and battery by boys under 21 with or against whom he plays?"

Reasoning from such situations the court decided that a minor of responsible age and comprehension could consent to elective surgery.

THE DOCTOR AND THE PRESS

There is a barrel of good sense in the appended editorial which appeared recently in the *Cleveland Academy of Medicine Bulletin*. Every physician should read it carefully, especially the latter half of the editorial which points out the damage which can be done by the chap who, knowingly or unwittingly, talks too soon or out of turn. Of course, the first part of the article emphasizing that the individual physician is the profession's best public relations agent is so true that it cannot be repeated too often. Here's the editorial:

"Living at a time when Medicine is a popular subject and in a city where there is superior medical reporting it is easy to forget that there were times and are places today where the prestige of the healing arts is in low regard.

"However there is no assurance that we continue to enjoy good press relations unless we merit them.

"No diligence on the part of the newly formed committee on public relations can preserve the status quo. Indeed the public relations of the Academy and of Medicine is in the hands of the individual practitioner. If we are indifferent (or seem to be), if we do not listen to our patients' complaints, if we keep people waiting needlessly, if we are unwilling to make house calls, if we base our charges on 'what the traffic will bear,' and if our personal appearance and conduct is not becoming to our position, we can undo countless hours of conscientious and devoted service by hundreds of our colleagues.

"Another matter, which will concern anyone of us only infrequently, is the releasing of information to newspapers and other news media. Since so many medical activities are cooperative affairs there is the possibility that someone may release information prematurely and thereby place all or some portion of the enterprise in jeopardy.

"It would seem that the surest way to avoid this is to ask ourselves this question before making any disclosure (even affirming a story) for publicity: *do I have concurrence of the other participating members, whether they be individuals or organizations?*

"Only by imposing some such rule on ourselves can we avoid premature release of information which is a source of embarrassment to all concerned.

"This suggestion is in no sense a restriction on news—but rather an assist in better reporting. It is to no one's credit to release an inaccurate or partially inaccurate account which must be modified or retracted later."

What To Write For

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

Your Social Security. Explains all the angles, including new features put into law in 1956, complete summary of coverage, benefits, how to apply and other details. Useful for distribution to employes. Write Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.

* * *

Alcoholics Are People . . . And So Many People Are Alcoholics. Describes work being done by Portal House Foundation in efforts to combat alcoholism in Illinois. Write Portal House, 734 N. Wabash Avenue, Chicago 11, Illinois.

* * *

Clinical Memoranda on Economic Poisons. Technical Development Laboratories of Technology Branch, Communicable Disease Center, conduct laboratory, field and clinical studies to determine toxic hazards to man involved in use of economic poisons in public health and agriculture. On basis of these research findings, clinical memoranda are prepared for many of more important economic poisons primarily for guidance of physicians in diagnosis and treatment of persons who may have had extensive or intensive exposure to pesticides. (30 cents.) Write Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.

* * *

Rehabilitation Trends; Midcentury to 1956. Monograph offers analysis of entire concept of comprehensive rehabilitation, gives reference material, charts and tables on rehabilitation. ($2) Institute for the Crippled and Disabled, New York City, New York.

* * *

Health Examination Blanks. Prepared by AMA on form 8 by 10 inches. Supplied as loose sheets or in pads of 100. (75 cents per 100 forms.) Write Bureau of Health Education, AMA, 535 North Dearborn St., Chicago 10.

* * *

What's up with Our Medical Schools? Gives factual inside story of operations and enrollments of nation's medical schools. Effectively disproves many criticisms levelled against them. Write OSMA, 79 E. State St., Columbus 15, Ohio.

* * *

Our Positive Program. This pamphlet is a statement of AMA policy on national medical issues. Write Department of Public Relations, American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

You and Your Public . . .

Important Public Relations Factor Is Involved in Collecting 'Slow' Bills; Advice on When To Call in Collection Agency Given

THE physician who practices good public relations will "look before he leaps" to turn an overdue account over to a collection agency, unless, of course, he has learned that the patient is an habitual dead beat.

He will check two factors before taking that step, the first factor being the situation surrounding the unpaid bill and the second being the matter of selecting a collection agency.

First, he will determine if the statement is being mailed to the right person at the right address. It also is a good policy to follow up with a letter or telephone call. This sometimes reveals that the person is willing but financially unable to pay the bill, and is reluctant to reveal his financial difficulties.

Often the doctor can arrange for the bill to be taken care of in monthly payments. This way, he not only collects the bill but saves the collection agency fee. Further, he earns the gratitude of the patient.

Supposing that he had turned to a collection agency without knowing that the bill was being sent to the wrong address or the wrong person. The collection agency turns on the pressure, wrongly, against what was thought to be a "dead beat." Somebody gets mad. He tells his friends and they tell their friends. The doctor gets on the blacklist.

In the matter of selecting a collection agency, caution again is important. There are many collection agencies—some good and some bad. The bad ones can, through unscrupulous methods, create irreparable damage. When in doubt, check with the OSMA office, which has considerable material on that subject.

Steps for determining if it is time to turn the bill over to the collection agency are outlined by Arthur Owens in an article published by *Medical Economics*. He advises the doctor to make sure that he has:

1. Sent the bill to the person responsible for paying it. For example, the patient may be the minor child of divorced parents and the aide has been dunning the wrong parent.

2. See to it that the patient understands all charges. To avoid misunderstandings here, discuss charges and get consent for special procedures in advance.

3. Investigated the debtor's ability to pay. Temporary unemployment, for example, can mean temporary inability to pay.

4. Sent bills regularly and promptly. After about three months, send a delinquent notice. If this doesn't get results, have an office aide write or phone to obtain a promise to pay or an explanation for nonpayment.

5. Try to trace the debtor who apparently has disappeared. This can be done through former employes, friends or relatives.

6. Made reasonably sure there is no chance of a malpractice suit. Wait until the statute of limitations has expired—regardless of whether or not the facts warrant such a suit.

If the bill still remains unpaid after all those steps have been taken, then it is time to call in the collection agency.

The doctor who follows this procedure is practicing good public relations. And after everything has been said, doctor-patient relationship makes the final determination in PR.

Early 1957 Health Forum Program Scheduled in Cincinnati

Names of 80 participants appear on the advance program of the 1957 National Health Forum on "Better Mental Health—Challenge to All Health Services" to be held March 20-22 at the Netherland Hilton Hotel in Cincinnati.

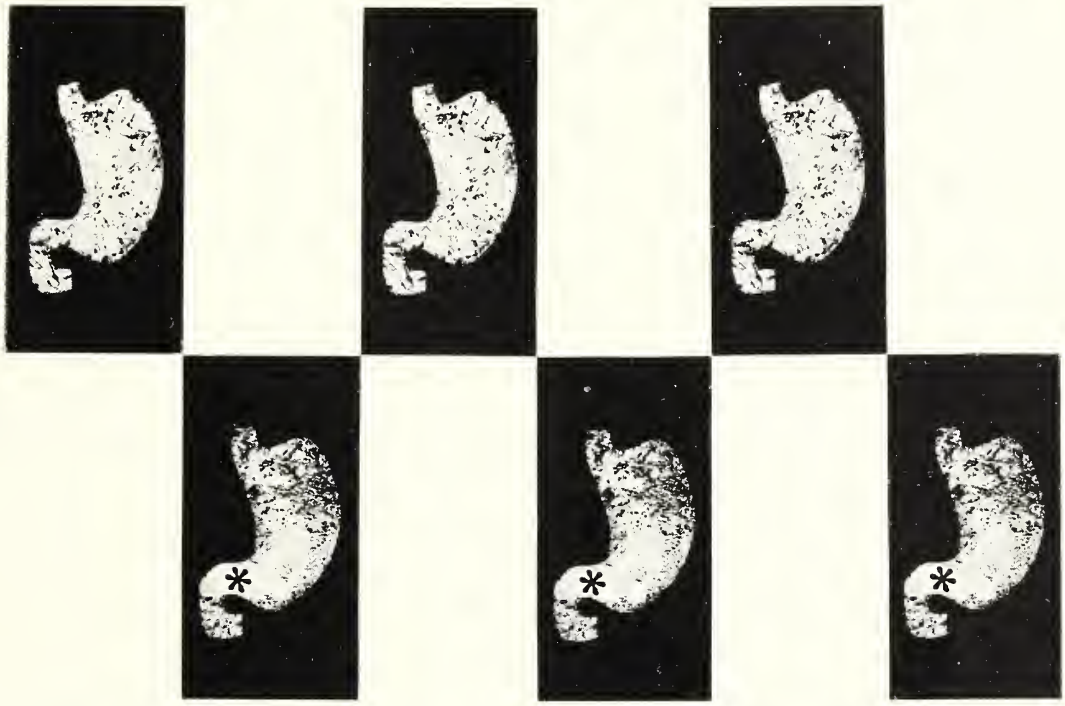
The program, and invitation to attend incorporating registration blanks, may be had on request to the National Health Council, 1790 Broadway, New York 19, N. Y. The Council sponsors the Forum each year in behalf of its national organization members, now 52 in number.

Keynote speakers at the opening session Wednesday morning, March 20, will be Harold D. Lasswell, professor of law and political science at Yale University, and Dr. Francis J. Braceland, psychiatrist-in-chief at the Institute of Living, Hartford, Connecticut, and president of the American Psychiatric Association. Dr. Braceland is chairman of the committee of 23 planning the Forum program.

Wylie Named Administrator of Workmen's Compensation

Chalmers P. Wylie, Columbus city attorney, who handled Workmen's Compensation cases while serving as an assistant attorney general, has been named administrator of the Bureau of Workmen's Compensation by Governor C. William O'Neill. Wylie, who will receive $18,000 a year and who will serve for a six-year term, succeeds Joseph J. Scanlon, Cincinnati, who left the post to join Senator Lausche. The post had been vacant since Scanlon's resignation.

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Pro-Banthine® Inhibits Excess Parasympathetic Stimuli in Peptic Ulcer

Medical literature now contains more than 500 references to the beneficial role of Pro-Banthine Bromide (brand of propantheline bromide) and Banthine® Bromide (brand of methantheline bromide) as evidenced by a marked healing response of peptic ulcers. Rapid symptomatic improvement, particularly with reference to pain relief, is followed by roentgenographic demonstration of crater filling.

The therapeutic action of Pro-Banthine in decreasing hypermotility and hyperacidity, together with the remarkable early subjective benefit, is a desired approach in the management of ulcers.

The initial suggested dosage is one tablet, 15 mg., with meals and two tablets at bedtime. An increased dosage may be necessary for severe manifestations and then two or more tablets four times a day may be indicated. G. D. Searle & Co., Chicago 80, Illinois, Research in the Service of Medicine.

SEARLE

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

Food and Drug Administration has warned that stem pessaries are dangerous and their use, sale and shipment should be discontinued at once on grounds that "stem-type" and wing-type intracervical and intrauterine pessaries are dangerous to health, and, regardless of their labeling, may be shown to be misbranded. FDA action is not applicable to other types of pessaries prescribed following surgery and for supportive purposes.

* * *

At third National Reorganization Conference in support of Hoover Commission proposals, former President Hoover warned, "The American people must realize that they cannot have every social and public works improvement of their dreams all at once, especially in a world where we have to defend ourselves from a monstrous international danger." Blue Cross Association President Basil MacLean, M. D., estimated 30 million Americans either already depend on U. S. for all or part of their medical care, or have the privilege of doing so.

* * *

Veterans Administration, revising medical research program, has appointed nine full-time clinical investigators to spend minimum of three-fourths of their working time on research. Formerly, such investigators spent major part of their time in patient care.

* * *

Public Health Service is continuing and possibly expanding training of professional public health personnel. Navy is expanding residency program. Air Force has initiated industrial medicine traineeships, with trainees to attend civilian medical institution for three years.

* * *

Investigation of air safety may result in stronger voice for medicine in determining policy on physical fitness requirements, examinations and regulations. Pilots, commercial airlines support tougher medical policy in CAB, CAA, contending air travel would be made safer.

* * *

Public Health Service has awarded $1.4 million in 104 research grants to support research in water pollution, water supply and air pollution. Two-thirds of the grants are for new studies.

* * *

Food and Drug Administration, taking a leaf from the FBI's book, has sent posters to all post offices and substations in U. S. a poster warning the public on the Hoxsey "cancer cure." Poster advises public of two Federal court decisions ruling the Hoxsey treatment to be worthless.

* * *

Bureau of Old Age and Survivors Insurance is working on setting up standards for determining disability that would enable non-medical men to determine if (1) disability qualifies applicant for OASI payments at age 50, and (2) qualifies him for freeze which protects against reduction of pension because of time he was disabled and unable to contribute to OASI. Bureau seeks system where non-medical men could determine eligibility by matching physician-certified physical conditions against OASI standards.

* * *

Small Business Administration is expected to get $80 million increase in funds, giving SBA a total of $230 million for long-term, low-interest loans. Proprietary hospitals and some other medical facilities are eligible for such loans.

* * *

Social Security Administration statistical report shows decline in expenditures for tubercular care on one hand, increase in expenditures for care of mentally ill.

* * *

Despite 12 per cent decline in private construction of all types during first 30 days of 1957, compared with December, 1956, 3 per cent gain was noted in hospital and institutional projects. Projects started in January were valued at $33 million, 27 per cent greater than January, 1956.

* * *

Internal Revenue Service has ruled that money paid directly to workers for health insurance is taxable, but that money paid directly into insurance fund is not subject to income tax.

Medical Aspects of World War II Covered in New Army Volume

Growth of the Army Medical Service during World War II to an organization able to treat almost nine million patients is described in the volume "The Medical Department: Hospitalization and Evacuation, Zone of Interior." The latest work is issued by the Army's Office of the Chief of Military History, part of the series dealing with the United States Army in World War II. It may be purchased for $4.00 from the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

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write for descriptive booklet

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In Memoriam . . .

Abram B. Bruner, M. D., Shaker Heights; Columbia University College of Physicians and Surgeons, 1916; aged 65; died January 9; member of the Ohio State Medical Association, the American Medical Association, the American Academy of Ophthalmology and Oto-Laryngology, American Ophthalmological Society, Association for Research in Ophthalmology; Fellow of the American College of Surgeons; diplomate of the American Board of Ophthalmology. Since the early 1920's Dr. Abram Bruner had been associated in practice with his uncle, Dr. William E. Bruner. He was a veteran of World War I, was a past-president of the Academy of Medicine of Cleveland and the Pasteur Club of Cleveland; a trustee of the Cleveland Medical Library, member of the Joint Hospital Committee of Cleveland and active in the Howard Dittrich Museum. Besides his uncle, he is survived by his widow, two daughters, two sons and two brothers.

Charles C. Butt, M. D., Nelsonville; Medical College of Ohio, Cincinnati, 1909; age 70; died January 14; member of the Ohio State Medical Association and the American Medical Association. Dr. Butt began practice in Nelsonville in 1909, following in the footsteps of his father, the late Dr. Samuel Butt. He was a member of the Knights of Pythias and the Presbyterian Church. Surviving are his widow and a daughter.

John L. Clifton, M. D., Columbus; Ohio State University College of Medicine, 1933; age 48; died January 24; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Clifton was a practicing physician in Columbus for all of his professional career. He was a member of the Methodist Church and the Columbus Athletic Club. Surviving are his widow, a daughter, a son, his mother and two sisters.

Richard Dexter, M. D., Boston, Mass.; Harvard Medical School, 1905; age 77; died January 19; former member of the Ohio State Medical Association; member of the American Medical Association; Fellow of the American College of Surgeons and diplomate of the American Board of Internal Medicine. Dr. Dexter was a practicing physician in the Cleveland area for some 45 years and moved to his native Boston upon his retirement about a year ago. He was a past-president of the Academy of Medicine of Cleveland. A son and a daughter survive.

Bernard Gonzales, M. D., Youngstown; University of Manila; age 26; died January 17. A native of the Philippines, Dr. Gonzales was an intern in St. Elizabeth Hospital. His parents survive.

Harry LaVerne Griffith, M. D., Columbus; Johns Hopkins University School of Medicine, 1918; age 66; died January 16; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Griffith had been a practicing physician for many years in Columbus. He was a member of the Methodist Church and Phi Chi, and was a veteran of World War I. Survivors include his widow, two daughters, a son and a brother, Dr. Joseph M. Griffith, also of Columbus.

John Heberding, M. D., Canfield and Youngstown; University of Pittsburgh School of Medicine, 1905; age 74; died January 23; member of the Ohio State Medical Association, the American Medical Association, American Roentgen Ray Society and the American College of Radiology, and diplomate of the American Board of Radiology. A native of Mahoning County, Dr. Heberding served all of his medical career in the Youngstown area. He was a recipient of the 50-Year Pin of the Ohio State Medical Association; was a member of the Masonic Lodge, the Rotary Club and the Methodist Church. His widow, two daughters and two sons survive.

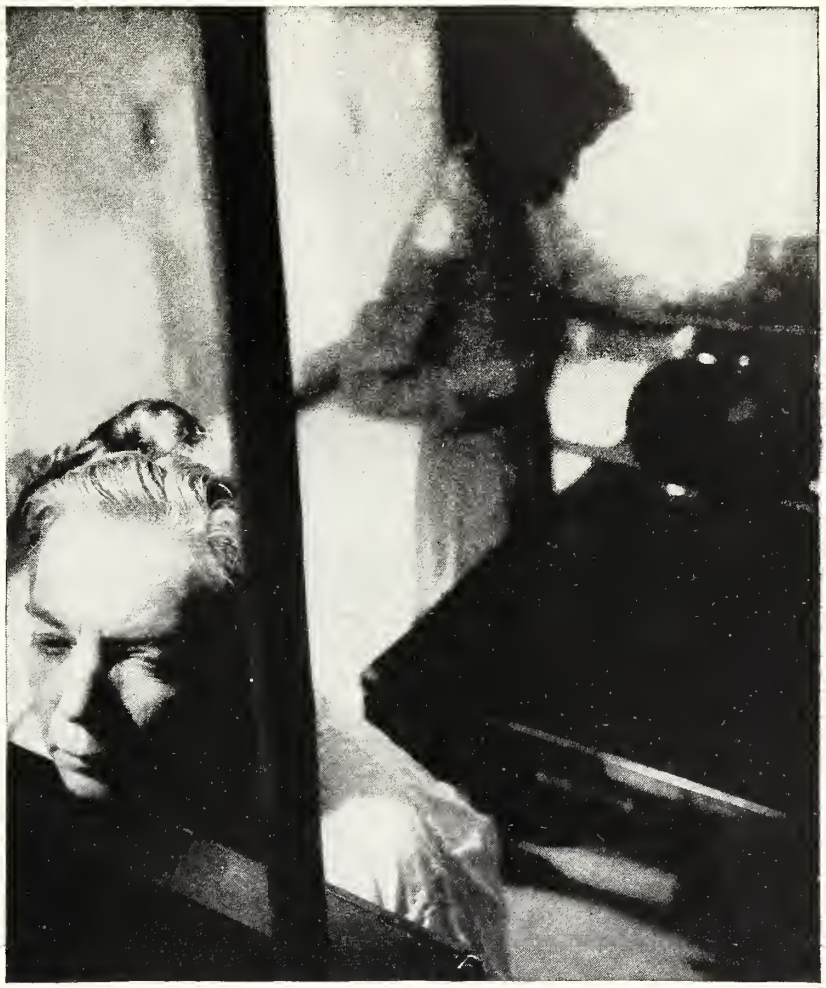
Anthony J. Kazlauckas, M. D., East Cleveland; St. Louis University School of Medicine, 1931; age 52; died January 18; member of the Ohio State Medical Association and the American Medical Association. Dr. Kazlauckas practiced for about 25 years in the Greater Cleveland area and for 13 years was deputy Cuyahoga County coroner. He was a member of the board of directors of the Lithuanian Savings & Loan Association. Survivors include his widow, a son and three sisters.

Arthur E. Koch, M. D., Mt. Healthy and Cincinnati; University of Cincinnati College of Medicine, 1913; former member of the Ohio State Medical Association. Dr. Koch was a practicing physician in the Greater Cincinnati area for all of his professional career. He was a Veteran of World War I. Survivors include his widow, a son and a sister; also a nephew, Dr. Carl A. Koch, also of Cincinnati.

H. R. Latta, M. D., Graysville; Ohio State University College of Medicine, 1917; Age 63; died January 18; member of the Ohio State Medical Association and the American Medical Association. Dr. Latta was a native of Graysville and served all of his professional career there, following in the footsteps of his father, the late Dr. A. F. Latta. He was a member of the Masonic Lodge and the Church of Christ. His widow survives.

Henry A. Lichtig, M. D., Cleveland; University of Michigan Medical School, 1916; age 63; died December 11; member of the Ohio State Medical Association and the American Medical Asso-

'Thorazine' relieved this patient's severe anxiety and helped her to gain insight.



"No X-ray sees my cancer."

"... nothing stops my pain."

'THORAZINE' CASE REPORT

patient: 60-year-old female. After death of relative from cancer, patient developed severe epigastric pain, was convinced pain was due to hidden malignancy which defied the X-ray. Her pain was unresponsive to antispasmodics. Her severe cancerphobia was untouched by sedatives and she refused psychotherapy.

response: Complete relief from pain was obtained after two weeks of 'Thorazine' (25 mg. q.i.d.). Dosage was gradually decreased over the next two months to a 25 mg. tablet on retiring.

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This case report is from the files of the patient's physician; photo professionally posed.

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ciation. Dr. Lichtig began practicing in Cleveland in 1920 after two years of military service. He was associated for many years with Polyclinic Hospital; was a member of B'nai B'rith and the Temple. Survivors include three sons, a brother and a sister.

Charles B. Messerly, M. D., Martins Ferry; College of Physicians and Surgeons, 1902; age 78; died January 31; member of the Ohio State Medical Association and the American Medical Association. Dr. Messerly had been a practicing physician in Martins Ferry since 1904 and was a recipient of the OSMA 50-Year Award. He was active also in numerous community affairs; was a former Belmont County coroner and served on the local board of education for some 25 years; was a past-chairman of the local Red Cross chapter and the Belmont County Polio Society. He was a member of the Masonic Lodge and the Baptist Church and was a veteran of World War I. A son, Charles D. Messerly, D. D. S., of Wheeling, survives.

Justus A. Mouser, M. D., Paulding; Ohio State University College of Medicine, 1916; age 64; died January 9; former member of the Ohio State Medical Association and the American Medical Association. Dr. Mouser practiced medicine for 40 years in Paulding County. His office was at Latty until a few years ago when he moved to Paulding. Dr. Mouser was a member of the Masonic Lodge and the Methodist Church. Survivors include his widow, two daughters, a son and a sister.

George B. Pantera, M. D., Buffalo, N. Y.; Georgetown University School of Medicine, 1936; age 47; died January 24; former member of the Ohio State Medical Association and later a member of the New York State Medical Association; member of the American Medical Association. Dr. Pantera was Columbiana County health commissioner for a short time before he returned to his native Buffalo in 1955. He formerly practiced in Virginia and West Virginia. Survivors include his father, three brothers and two sisters.

James B. Poling, M. D., Lima; Miami Medical College, Cincinnati, 1904; age 79; died January 17; member of the Ohio State Medical Association and the American Medical Association. A native of Allen County, Dr. Poling served virtually all of his professional career in Lima and vicinity, and was a recipient of the OSMA 50-Year Award. For 32 years he served as city health commissioner. A veteran of World War I, he was a member of the American Legion. Other affiliations included membership in the Presbyterian Church and several Masonic orders. A son, two brothers and three sisters survive.

Robert Rodin, M. D., Champaign, Illinois, formerly of Youngstown, Ohio; University of Illinois College of Medicine, Chicago, 1931; age 50; died January 10; former member of Ohio State Medical Association. Dr. Rodin was a Youngstown obstetrician and gynecologist before he became associated with the University of Illinois at Champaign two years ago. He is survived by his widow and two daughters.

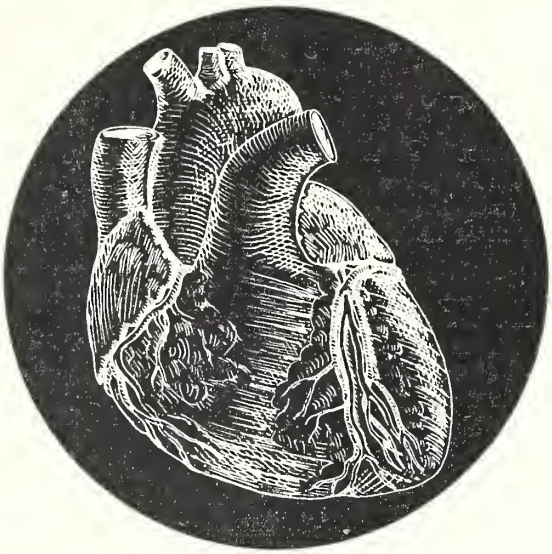
Attilio Rosapepe, M. D., Youngstown; medical degree from Regia University, Italy, 1911; age 74; died January 28; member of Ohio State Medical Association and the American Medical Association. Dr. Rosapepe practiced in Youngstown more than 40 years, coming to the United States in 1913. For eight years he was Italian consular agent for seven northeastern Ohio counties. During World War I he served as a captain in Italy's medical corps. He is survived by his widow, who also is a physician and was a classmate at the University of Naples, four sons, a daughter and a brother.

Ross Philip Rusk, M. D., Cadiz; Starling Medical College, Columbus, 1902; age 79; died January 3; member of the Ohio State Medical Association and the American Medical Association. In 1952, after more than 50 years of practice, Dr. Rusk retired following illness. He was a member of the Presbyterian Church and the Masonic Lodge. Surviving are his widow and three children, Dr. R. Phillip Rusk, Dubuque, Iowa, Capt. William S. Rusk, Bethesda, Md., and Mrs. John Grove, Cadiz, and a sister.

Harry Simpkinson, M. D., Pleasant Ridge; Medical College of Ohio, 1896; age 83; died January 21 of injuries received when struck by an automobile. After five years of medical practice, Dr. Simkinson left the profession to become a mechanical engineer. He is survived by his widow, a son and a sister.

James E. Stewart, M. D., Akron; Ohio State University College of Medicine, 1916; age 70; died January 27; former member of the Ohio State Medical Association and former member of the American Medical Association. Dr. Stewart, a roentgenologist, installed the first x-ray department at Akron City Hospital and at the Firestone Tire and Rubber Co. He is survived by his widow, two daughters and two brothers.

George E. Winn, M. D., Defiance; University of Nashville, Tenn., Medical Department, 1900; age 79; died January 18; member of the Ohio State Medical Association and the American Medical Association. Dr. Winn had been a practicing physician in Defiance County for more than 55 years. In 1952 he was awarded on OSMA 50-Year Pin. He attended Ohio Medical University for a year, in 1901, and was a captain in the Army Medical Corps during World War I. Surviving are his widow and a son by a former marriage.



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You and Your AMA . . .

Some Highlights and Sidelights on What Your American Medical Association Is Doing in Its Extensive and Far-Reaching Program

THE American Medical Association is asking physicians and lawyers in New England and the Eastern States (including Ohio) to attend a medicolegal symposium in Philadelphia, March 20 and 30.

"Medicine and the law must work together so frequently that we feel open discussions of mutual problems would be of great assistance to the two professions," said C. Joseph Stetler, Director of the American Medical Association's Law Department, in announcing the meeting.

One of a series of three such symposiums to be held during March in various sections of the United States, the Philadelphia symposium will feature such subjects as trauma and disease, medical expert testimony and the medical witness. In addition, a mock trial demonstration will take up the introduction in court of chemical tests for intoxication.

Registration fee for the meeting—to be held at the Benjamin Franklin Hotel—is $5.00.

Applications for attendance, together with the registration fee, should be sent to the Law Department, American Medical Association, 535 North Dearborn, Chicago 10, Illinois.

Other meetings in the current medicolegal series will be held in Atlanta, March 15-16 and in Denver, March 22-23. Last year similar symposiums were held in New York, Chicago and Omaha.

"NOMENCLATURE" INSTITUTE

The American Medical Association recently announced that a short course on the use of the *Standard Nomenclature of Diseases and Operations* in the doctor's office, clinic or hospital will be held June 17-19 at the Indiana University Medical Center, Indianapolis.

FILM ON HEREDITY AVAILABLE FROM AMA

The basic story of heredity, sex determination, sex roles and attitudes within the framework of heredity and environment is dramatically told in a new color film which has recently been added to the AMA Film Library. The 18-minute sound film, "Human Heredity," was designed primarily for junior high students although older persons also will find it informative.

NEW AMA SLIDEFILM PINPONTS QUACK DEVICES

More than a dozen mechanical quack devices and gadgets play the villain in a color slidefilm with sound just released by the AMA Bureau of Investigation. The 15-minute filmstrip, "Mechanical Quackery," is supplemented by narrative description of the devices and the fraudulent uses to which they have been put. It is available —on loan—to medical societies, service and fraternal groups and schools. Oliver Field, Bureau director, describes the film as a public education experiment.

COLD WEATHER DAMAGES AMA EXHIBIT

Even babies embedded in solid blocks of plastic have to be sheltered from the cold. Five of the 12 fetuses embedded in plastic blocks for the AMA exhibit, "Life Begins," were damaged recently by exposure to below freezing temperatures while enroute to Springfield, Illinois, for showings by the Illinois State Department of Public Health. Preservatives inside expanded, splitting the plastic blocks. The AMA Bureau of Exhibits reports that the five fetuses are being re-set at the University of Illinois.

NEWSCOPES

The American Medical Education Foundation wound up its fifth year of operation with a record total of $1,072,717 in contributions for the country's 83 medical schools. This represents a 41 per cent increase over the previous year. . . . The Committee on Relationships Between Medicine and Allied Health Agencies—a committee of the AMA Board of Trustees—recently developed a brief statement designed to assist medical societies in this activity. Copies are available to physicians from the Council on Medical Service.

AMA Field Director Is Appointed

Thomas A. Hendricks has been appointed by the AMA Board of Trustees to the newly created position of field secretary, a two-way communications assignment in which he will:

1. As field representative from the secretary's office in Chicago interpret AMA policies and programs for state and county medical societies, and

2. By virtue of his accessibility in the field, be an important link in the communications chain between state and county medical societies and the AMA. Through him another avenue is available for transmitting to AMA headquarters and the Board of Trustees up-to-date reports on local problems and attitudes.

Succeeding him as secretary of the Council on Medical Service will be George Cooley, who has handled much of the Council's work. He has been named acting secretary.

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Welfare Costs Skyrocket . . .

Expenditures for Government-Sponsored Social Welfare Programs Indicate Increase of Some 400 Per Cent During Ten-Year Period

THE COST of government-sponsored social welfare programs in the United States has risen fivefold in the last decade, according to *Insurance Economics Surveys*, monthly publication of the Insurance Economics Society of America.

Following, in part, is the publication's analysis of the program, primarily the Federal part of the program:

Compilations made by the U. S. Department of Health, Education and Welfare show that expenditures for these programs from the public purse —Federal, State and local combined—rose from $4½ billions in 1945 to some $21½ billions in 1955. This is a far greater rate of growth than the economy has shown in the period. National income, for example, gained 79 per cent between 1945 and 1955 as against a rise of some 400 per cent in social welfare expenditures for the decade.

MEASURE OF COST

Right now the bill for these programs comes to the equivalent of about $125 for every man, woman and child in the population, and is still heading upward under the pressure to expand and to liberalize benefits. The comparable figure a decade ago was little more than $30 per capita. As far as combined Federal, State and local expenditures are concerned, social welfare outlays alone currently represent approximately a fifth of the government spending dollar. About 60 per cent of the aggregate cost comes from Federal funds.

As a result of the trend, social welfare has become one of the big and inflexible elements in the cost of government in this country, with a built-in growth factor besides.

The high cost of government continues to be one of the major problems facing the nation, it is the direct cause of the magnitude of the tax burden borne by the public. Furthermore, the level of government spending today represents a force that is contributing significantly to the inflationary pressures in an economy that is straining its resources of manpower, materials and capital and investment funds.

THREAT OF INFLATION

Obviously, further dilution of the dollar's buying power will depreciate the value of a social welfare benefit as well as impair the savings and protection programs which tens of millions of Americans have voluntarily built up for themselves in Life Insurance, pension and retirement programs, and other thrift mediums.

Rising social welfare expenditures are superimposed on the need of maintaining a costly national defense establishment, yet pressures for further spending are in the ascendancy and economy is in retreat. This is the reverse of what the times and conditions call for.

The Federal Government alone, for example, is slated to spend some $69 billions in the current fiscal year which ends next June, the fifth highest budget on record and exceeded in the past only in wartime. State and local outlays are rising to new records at the same time to meet the needs of an expanding population. Taking the three levels of government together, the latest figures show that combined public expenditures now add up to more than $100 billions a year and are taking a quarter of the entire output of the American economy.

LEADING AREAS OF GROWTH

The biggest welfare classification, and the one showing the largest rate of growth, is a number of government-sponsored retirement and allied programs backed by the taxing power. The group includes OASI, Railroad Retirement, public employee retirement programs, unemployment insurance and workmen's compensation. Expenditures under these programs aggregated practically $10 billions in 1955 as against little more than $1¼ billions in 1945, a rise of over 600 per cent in the period. OASI alone represented 45 per cent of the benefit total of this group in 1955 as compared with only 21 per cent in 1945.

A series of veterans' programs, led by pensions and compensation, ranks second. Expenditures under these programs totalled about $4.4 billions in 1955 as against less than a billion dollars in 1945, a rise of close to 400 per cent for the period. However, expenditures under veterans' programs were substantially higher during the early post-world War II years when outlays under readjustment allowances and the GI education bill reached their peak.

The other major elements of the social welfare bill are: Public aid, primarily public assistance, $3 billions in 1955 as against a billion dollars in 1945, up 200 per cent; public health and medical services, $3.3 billions as compared with a billion dollars, up 230 per cent; and a miscellaneous group of other welfare services, $924 millions as against $210 millions, up 340 per cent.

Medical Organizations Join Health Officials in Sponsoring Dayton VD Seminar

Recent developments have resulted in a shift of venereal disease diagnosis and management from clinics and specialists to the average physician's office. This shift emphasizes the need for increased postgraduate educational opportunities in the field.

With the foregoing observation, Dr. Frederick H. Wentworth, chief of the Division of Communicable Diseases, Ohio Department of Health, announced a seminar in Dayton on April 17 especially planned for general physicians to aid them in application of the optimal methods of diagnosis and management of patients with venereal disease.

This course is offered to all physicians of the area with postgraduate credit of 4½ hours, Category I, approved by the Ohio Academy of General Practice. The program is jointly sponsored by the Montgomery County Medical Society, the OAGP, District 2, Dayton and Montgomery County Social Hygiene Associations, The Dayton Health Department, and the Ohio Department of Health. Costs are borne by the Ohio Department of Health and no tuition fee will be charged.



EVAN THOMAS, M. D.

The program will be in the Biltmore Hotel with registration opening at 9:00 a. m. and the program at 9:20 a. m.

Featured guest speaker will be Dr. Evan Thomas, consultant in VD, New York State Department of Health; emeritus professor of clinical medicine (syphilology), New York University; formerly director of syphilis service at Bellevue Hospital.

The program has been announced as follows:

Presiding at morning session—Dr. Dean Dooley, president of the Montgomery County Medical Society.

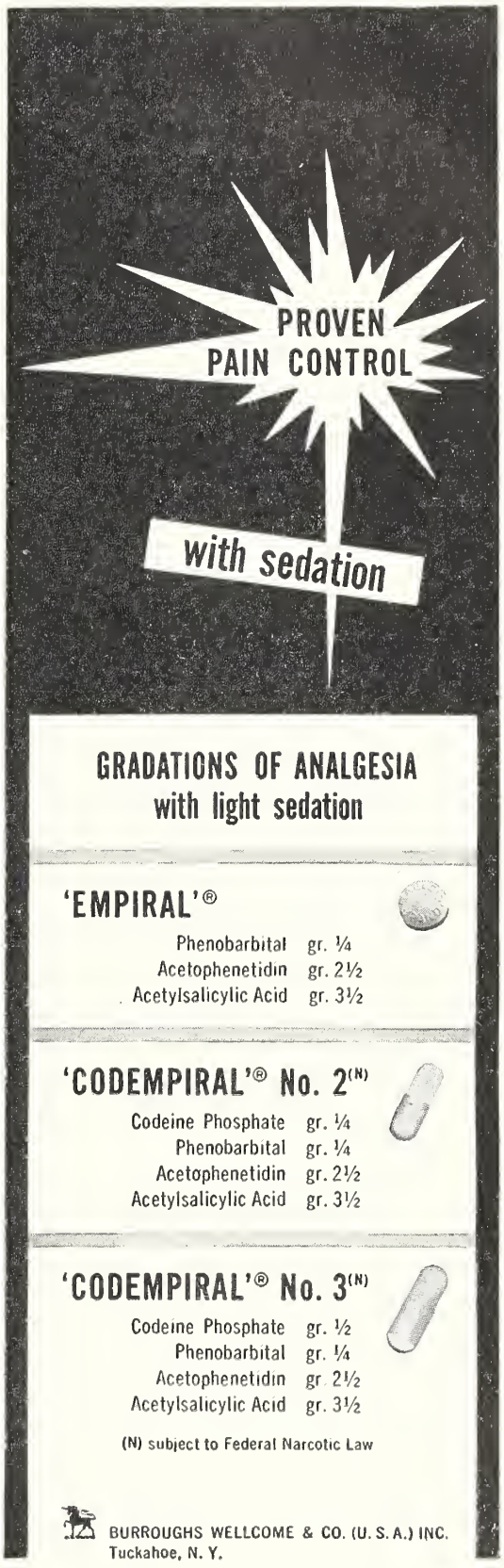
Welcome by Dr. H. H. Williams, Dayton health commissioner, and Dr. Roscius Doan, Miamisburg, president of the Ohio Academy of General Practice.

Highlights in the Fight Against Venereal Disease, Dr. Otis Anderson, assistant surgeon general and chief of the Bureau of State Services, U. S. Public Health Service, Washington, D. C.

Diagnosis and Management of Syphilis in General Practice Today, Dr. Thomas.

The Current Status of Venereal Disease in Ohio Today, Dr. Wentworth.

Luncheon and business meeting (election of



officers), Academy of General Practice, District 2, Dr. W. E. Chaney, president, presiding.

Presiding at afternoon session—Dr. Chaney.

Laboratory Tests for Syphilis, Dr. Harold Magnuson, chief of occupational health, USPHS, Washington, D. C.

The Current Status of Gonorrhea, Dr. Warfield Garson, chief of the operational research section, venereal disease program, USPHS, Washington, D. C.

Panel Discussion, all speakers of the day; moderator, Dr. Gordon Munson, staff physician, Dayton Health Department and member of the OAGP.

Recent Opinions Rendered by The Attorney General

Following are syllabi of recent opinions given by C. William O'Neill, while he was Attorney General of Ohio:

GUARDIANSHIP OF DELINQUENT CHILDREN

1. The Department of Mental Hygiene and Correction has the exclusive guardianship of delinquent children committed to it by a Juvenile Court, and such guardianship may not be transferred to the Division of Social Administration, Department of Public Welfare, merely with the consent of the committing court, but such guardianship continues until the commitment order expires or is terminated upon application to the committing court as provided in Section 2151.38, Revised Code.

2. A committing Juvenile Court may, under the provisions of Section 2151.36, Revised Code, at the time of commitment, obligate the county for such expenses as are authorized and approved by the Judge of the Juvenile Court for the care of a delinquent child committed to the Department of Mental Hygiene and Correction for placement in a private family home or institution operating under such rules and regulations as are adopted by the department.

3. A county child welfare board may not, under authority of Section 335.16, Revised Code, enter into an agreement with the Department of Mental Hygiene and Correction with respect to the care and placement of a delinquent ward of the department.—Opinion No. 7007.

* * *

FINANCING MENTAL HEALTH CLINICS

An expenditure for a county's contribution for the maintenance and support, and the providing of facilities, for mental health clinics is a health expenditure and if the funds for health purposes are insufficient a levy may be made for the purpose of supplementing the general fund for the purpose of making appropriation for health under the provisions of Section of 5705.191, Revised Code. Funds derived from such levy may not be earmarked for any special health purpose but

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are available for appropriation by the county commissioners for all health expenditures.—Opinion No. 7001.

* * *

AREA JURISDICTION OF BOARDS OF HEALTH

1. The board of health of a general health district of a county, in the exercise of its powers relative to public health, has jurisdiction over buildings and property belonging to the county and situated within its territory, but not when the same is located in a city which is not a part of such health district.

2. The State Department of Health alone has jurisdiction in matters relating to the public health, over buildings or other property belonging to the state, and the board of a general health district in a county has no powers or duties to such property located in its district, except to carry out orders of said state department.

3. The jurisdiction of a county district board of health extends to property belonging to a municipality located within the territory of such district.—Opinion No. 7436.

* * *

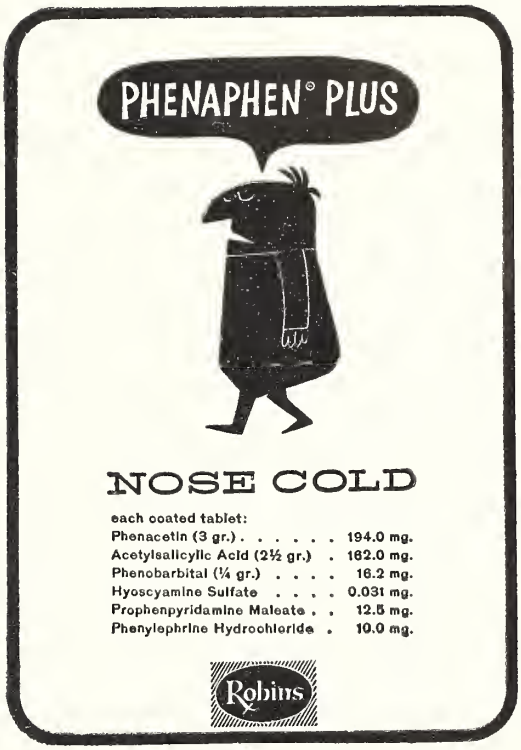
STATUS OF MENTAL PATIENTS

1. A patient who has been adjudged mentally ill by a probate court and has been ordered either placed in a receiving hospital or committed to a state hospital pursuant to Section 5123.23, Revised Code, thereby becomes subject to Section 5123.57, Revised Code, and, accordingly, is incompetent to contract or execute instruments without the allowance and approval of such court.

2. A patient who, pursuant to the provisions of Section 5123.23, Revised Code, has been placed in a receiving hospital may be transferred to a state hospital by the director of mental hygiene and correction or the commissioner of mental hygiene pursuant to the authorization as contained in Section 5123.47, Revised Code, provided the director or commissioner, as the case may be, makes the necessary medical finding that the patient is a proper subject for admission to such state hospital.

3. The propriety of the original confinement or the continued confinement of any patient in a state hospital or other institution is always subject to review and consideration by the appropriate courts on a writ of habeas corpus.

4. Where a person, who is suspected of being mentally ill, is confined without a warrant in a receiving hospital pursuant to Section 5123.22, Revised Code, for the limited period therein prescribed, such physical and mental care and treatment may be rendered, as will, in the considered opinion of the supervisory authority of such hospital, avoid further deterioration in such person's condition and protect him from causing injury to himself.—Opinion No. 7106.



Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES—SPRING, 1957

SURGERY—Surgical Technic, two weeks, Apr. 29, May 13. Surgery of Colon & Rectum, one week, May 6. General Surgery, one week, May 13. Surgical Anatomy & Clinical Surgery, two weeks, June 17. Treatment of Varicose Veins, two days, Apr. 29. Fractures & Traumatic Surgery, two weeks, June 17. Gallbladder Surgery, three days, June 24. Surgery of Hernia, three days, June 27.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, June 17. Vaginal Approach to Pelvic Surgery, one week, June 10. General & Surgical Obstetrics, two weeks, May 6.

MEDICINE—General Review Course, two weeks, Apr. 29. Electrocardiography & Heart Disease, two-week basic course, July 8. Gastroenterology, two weeks, Apr. 15.

RADIOLOGY—Diagnostic X-Ray, two weeks, Apr. 29. Clinical Uses of Radioisotopes, two weeks, May 6. Radioactive Iodine, one week, Apr. 1.

UROLOGY—Two-week course, Apr. 1. Cystoscopy, ten days, by appointment.

PEDIATRICS—Two-week general course, May 13.

TEACHING FACULTY — ATTENDING STAFF OF COOK COUNTY HOSPITAL

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Activities of County Societies . . .

First District

(COUNCILOR: FRANK H. MAYFIELD, M. D., CINCINNATI)

BUTLER

Following are excerpts from the *Hamilton Journal:*

Dr. Corliss R. Keller, one of the community's most highly respected physicians, was honored by his fellow doctors during a dinner marking Dr. Keller's 50th year in the practice of medicine in the City of Hamilton.

Dr. Keller was the honored guest at a meeting of the Butler County Medical Society held in the dining room of the Eugene Hughes Memorial Hospital. More than 50 physicians and others were in attendance.

Dr. Keller, in addition to being a typical "family doctor," has also been a leader in the community's medical field for many years. He has served as chief of staff of both Mercy Hospital and the Fort Hamilton Hospital.

Dr. Keller was graduated from the old Miami Medical College (now the University of Cincinnati Medical College), and then returned to Hamilton to start his practice.

During the dinner meeting, Dr. Keller was praised by Dr. Frank Mayfield, Cincinnati, First District Councilor of the Ohio State Medical Association. Words were also spoken by Dr. Donald Blizzard, Middletown, president of the county Medical Society; and by David Disch, administrator at Hughes Hospital.

CLERMONT

Dr. Emily R. Hess, of Cincinnati, discussed rehabilitation at the February 20 meeting of the Clermont County Medical Society. Host for the meeting was Dr. C. F. Barber.

HAMILTON

The following report of the February 5 meeting was contained in the *Cincinnati Times-Star:*

The Academy of Medicine of Cincinnati, preparing to celebrate its centennial, has conferred honors on its historian and five members who have been practicing for 50 years.

Prof. Reginald C. McGrane, head of the University of Cincinnati History Department who compiled the Academy's history, was made an honorary member Tuesday night.

He also received an inscribed silver platter and the first copy of the historical volume, *The Cincinnati Doctors' Forum.*

Ohio State Medical Association certificates of award, for physicians who received licenses 50 years ago, were presented to Dr. Harry G. Nelson, Ft. Thomas; Dr. H. H. Schulze, Dr. J. L. Tuechter, Dr. Millard Wallenstein, and Dr. Victor P. Wilson.

In a talk on the Academy's 100-year span, Dr. McGrane said members may well be proud of "the rich heritage of history, tradition and high ideals bequeathed to them by their predecessors."

The meeting was the first of a series of centennial celebration programs, to be climaxed February 27 to March 5 with a health exposition in Music Hall.

In cooperation with WLW, the Academy has been running a series of radio programs on Saturday mornings. The program consists of a series of interviews by Miss Jane Lynn with local physicians.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

CLARK

The Clark County Medical Society held a dinner meeting in the Shawnee Hotel, Springfield, on January 21. Guest speaker was Dr. Albert A. Brust, associate professor of internal medicine, Emory University School of Medicine, Atlanta, Georgia, and director of the Hypertension Research Laboratory. His topic was "Clinical Problems in Hypertension."

DARKE

The subject, "Radioactive Isotopes in General Practice" was discussed by Dr. Robert Zipf, Dayton, at the January 15 meeting of the Darke County Medical Society. The meeting was held in the Treaty City White Shrine Temple of Greenville.

MONTGOMERY

The Montgomery County Medical Society telephone service was the subject of a feature article in the *Dayton Daily News;* the occasion—the handling of its millionth phone call on January 30. Following are statistics on performances since the service began on October 29, 1951:

To date the service has handled 7,675 acute emergencies such as heart attacks, hemorrhaging, poisonings, accidents and the like. It has put 37,042 persons who had no family doctor in touch with physicians and has made 161,646 calls to locate physicians or relay messages to them.

Average length of elapsed time between a call to the society and a physician communicating with the caller is four minutes.

The service has grown from 87,571 calls in its first year of operation to 253,598 in 1956. Largest number of calls handled in one day—1,099—came on January 2 of this year and second largest number—1,038—on New Year's Eve, but most were during daylight hours.

Acute emergency calls are running about three a day. Heaviest volume of all calls handled

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Adult dosage for ACHROCIDIN Tablets and new, caffeine-free ACHROCIDIN Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children according to weight and age.

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Phenacetin	120 mg.
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comes between 12 noon and 1 p. m. and 5 and 6 p. m.

The service keeps tabs on where a doctor may be located, should he be needed and in addition has extensions to 125 doctors' offices so it can answer their phones if the doctor's office doesn't answer.

To handle the calls the service has 10 operators each of whom takes a two-month training period.

The Dayton Surgical Society met on January 29. The speaker was Dr. Emmerich von Haam, chairman of the Pathology Department, Ohio State University, whose topic was "Death of Medico-Legal Importance."

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

Ancel Keys, Ph. D., director of the Laboratory of Physiological Hygiene, University of Minnesota, was guest speaker for the Inter-Hospital Postgraduate Lecture Series, February 14 and 15. The program was presented by the Medical Advancement Trust of Maumee Valley Hospital and the Northwestern Ohio Heart Association.

Theme of the series was "Coronary Heart Disease, Metabolism and Epidemiology." Topics discussed by the speaker included: The measurement of obesity and body composition; obesity vs. overweight in heart disease; cholesterol-lipoprotein system and the diet; the diet, blood coagulation and thrombosis; non-dietary factors in coronary heart disease; the epidemiology of coronary heart disease.

The Pathology Section of the Toledo Academy met on February 8. The subject, "Hereditary Diseases of Metabolism with Hepatic Manifestations," was discussed by Dr. Edward A. Gall, professor of pathology at the University of Cincinnati.

The Surgical Section met on February 22 with guest speaker, Dr. Michael L. Mason, professor of surgery, Northwestern University, Chicago. His subject was "Diagnosis and Management of Hand Injuries."

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

ASHTABULA

The following officers are serving the Ashtabula County Medical Society for 1957: President, Dr. Harold C. Franley, Jefferson; Vice-President, Dr. Walter J. Brown, Conneaut; Secretary-Treasurer, Dr. Arthur B. Shaul, Ashtabula.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

"Plan Better Public Relations for Medical Society." That was the heading over a photograph and article in the *Youngstown Vindicator*. The photograph showed representatives of the Medical Society meeting with radio-TV and newspaper personnel. Following are excerpts from the article, clipping of which was furnished *The Journal* by the Society's correspondent, Dr. Clyde K. Walter:

A new program designed to publicize the services of the Mahoning County Medical Society to the public was outlined Thursday when representatives of the society and news media met at the Youngstown Club.

The delegation of medical men was headed by Dr. Stephen W. Ondash, president of the society, and Dr. L. S. Shensa, chairman of the society's public relations committee. Meeting with them were representatives of *The Vindicator*, WKBN and WFMJ.

In a brief outline, Dr. Shensa presented a number of the problems in developing good public relations. He listed many of the achievements locally and said they should be made known to the public through the various news media.

Dr. Ondash promised cooperation of the society and said that when some medical matters may come up involving the local society, there will be someone available to make comment on them.

Robert Locke, WFMJ program director; Sid Davis, WKBN news director, and I. L. Mansell,



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managing editor of *The Vindicator*, presented a number of problems as seen from the viewpoint of news-gathering agencies, where many times speed is essential in obtaining information.

They were assured by Dr. Ondash and others that arrangements will be made to have such matters handled properly. All three emphasized that the public in general is vitally interested in medicine and oftentimes there may be human interest and general news stories which should be publicized but have not been in the past.

Dr. Ondash told of some plans under discussion now, including renewed activity on the part of the society to obtain a full-time health commissioner for Youngstown. He said the main objective of the meeting was to set up procedures for "an orderly distribution of the news."

Others at the meeting included Mary B. Herald, executive secretary of the society; Dr. Jack Schreiber, Dr. F. S. Gaylord, Dr. Hugh Bennett, Dr. Robert Fisher, Dr. Richard Murray, Dr. C. K. Walter, Paul Herald of the medical society staff and Ann Przelomski, *Vindicator* reporter.

The Academy joined with the Mahoning Academy of General Practice and the Youngstown Area Heart Association to promote a heart program and clinic on February 19. Guest speaker for the occasion was Dr. William B. Bean, professor of internal medicine, State University of Iowa.

SUMMIT

The Summit County Medical Society presented Dr. John H. Bland, associate professor of medicine, University of Vermont, at the February 5 dinner meeting. The dinner was held at the Akron City Club with the program in the Akron General Hospital auditorium, where Dr. Bland spoke on "The Metabolic Defects of Congestive Circulatory Failure."

TRUMBULL

Sixty-five members were present at the January meeting of the Trumbull County Medical Society to hear a discussion of anemia by Dr. M. E. Lahey, assistant professor of pediatrics at Children's Hospital, Cincinnati, Dr. Ralph H. Jamison, chairman of public relations for the Society, reported.

This was the first meeting at which the officers for 1957 assumed their duties. Officers are: Dr. Joseph A. Browning, president; Dr. Aubrey A. Sparks, president-elect; Dr. Robert J. Willoughby, secretary-treasurer. Delegates are Dr. E. R. Westbrook and Dr. E. Gray Caskey; alternates, Dr. Joseph M. Gledhill and Dr. Ralph H. Jamison.

The Society is sponsoring a series of 15-minute radio programs over the local station.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

Members of the Belmont County Medical Society, in conjunction with the Belmont County



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Bar Association, held a dinner and program at the Belmont Hills Country Club on February 21. The subject was "The Doctor and the Law."

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D., LANCASTER)

GUERNSEY

The following record is quoted from the *Cambridge Jeffersonian:*

Tribute was paid Dr. C. A. Craig at a recent luncheon-meeting at the Berwick Hotel of the Guernsey County Medical Society in recognition of 50 years of service as a practicing physician.

A pin and certificate were presented him by Dr. William A. Monger, Lancaster, counselor for the Eighth Medical District of Ohio, who also congratulated him on his outstanding record as a physician. Others likewise expressed commendation, among them being Dr. Henry L. Wells, who was similarly honored last year.

Born and reared in Westland Township on a farm near Claysville, Dr. Craig attended country school at Sugar Grove, then went to Muskingum College, paying for his education, like most young men of those days, by teaching school at Pleasant City and College Hill in Spencer Township.

Graduating from Starling Medical College in 1906, Dr. Craig later took additional work in New York Postgraduate Medical College and Harvard Medical School.

He first began practicing his profession at Calais, Monroe County in July, 1906, but a few months later moved to Ava where he remained until 1911, serving part of this time as coroner of Noble County. He moved to Senecaville in 1911, remaining until 1919 when he came to Cambridge, opening his office at 114 E. Eighth St., where he is still practicing.

PERRY

The Perry County Medical Society met on January 17 at Weaver Tea Room, New Lexington. The meeting was called to order by Dr. S. N. Lord, acting secretary, Dr. James Miller, president, presiding. The members present were: Drs. O. D. Ball, Charles Bope, Joseph Clouse, Michael Clouse, Arthur Dobosiewicz, Ralph E. Herendeen, Jr., Sydney Lord, Charles McDougal, James Miller and George Tedrow.

Dr. C. B. McDougal, New Lexington, was elected president and Dr. Joseph Clouse, Somerset, president-elect.

Dr. Charles Bope was selected as delegate to the State Convention and Dr. Michael Clouse, alternate. Dr. S. N. Lord was selected as program chairman for future meetings. Dr. O. D. Ball, New Lexington, was elected secretary-treasurer.

After discussion, members voted that dues remain the same as previously. A resolution was presented and approved offering a vote of thanks to Dr. S. N. Lord for his effort and time spent in getting the members of Perry County Medical Society together for reorganization. It was also voted that future meetings be called three times a year or more often by the president.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

LAWRENCE

The metropolitan Medical Societies have their printed bulletins, but the Lawrence County Medical Society is accomplishing the same purpose with the aid of a typewriter and duplicating machine. A four-page bulletin has appeared, full of comments, excerpts on happenings in the profession and reports of local society news—excellent information for members. President of the Society is Dr. Harry Nenni and Secretary, Dr. George N. Spears, both of Ironton.

SCIOTO

Following is an excerpt from a report in the *Portsmouth Times:*

Three Portsmouth doctors were handed distinguished honors by associates in their profession.

Singled out for congratulations at the Scioto County Medical Society's annual banquet in Elks Auditorium were:

Dr. Oscar Micklethwait, for 50 years' service.

Dr. O. D. Tatje, for 50 years' service.

Dr. Ralph W. Lewis, for the Award of Merit from the American Medical Education Foundation.

Dr. Carter L. Piteher, Ninth District Councilor on behalf of the society, presented the two half-century veterans with certificates.

Dr. B. U. Howland, president of the society, called up Dr. Lewis for his surprise award.

The latter was given to the local surgeon "for your outstanding contribution to the preservation and maintenance of the high standards of medical education in the United States of America."

Both the 50-year veterans, now 75, began their medical practice at the age of 25.

The Society met at the Nurses' Recreation Hall of General Hospital on January 14 for a program and buffet supper. The speaker was Chester Fitch, attorney and president of the local Bar Association who spoke on medico-legal problems.

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l-Lysine	300 mg.	Pyridoxine (B_6)	5 mg.
Vitamin B_{12}	25 mcgm.	(INCREMIN Drops contain 1% alcohol)	
Thiamine (B_1)	10 mg.		

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Activities of Woman's Auxiliary . . .

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President—Mrs. William H. Evans, 291 Park Ave., Youngstown

President-Elect—Mrs. V. R. Frederick, 145 Tanglewood Dr., Urbana

Vice-President: 1—Mrs. C. H. Bell, Mansfield
2—Mrs. W. R. Gibson, Oak Harbor
3—Mrs. C. A. Colombi, Cleveland

Recording Secretary—Mrs. Lester W. Sontag, Livermore St., Yellow Springs

Corresponding Secretary—Mrs. Earl Young, 170 Brookline Ave., Youngstown

Past-President and Finance Chairman—Mrs. Karl Ritter, 1420 Shawnee Rd., Lima

BELMONT

Past presidents of the Belmont County Medical Auxiliary were honored at the Auxiliary meeting on the afternoon of January 24, at the Belmont Hills Country Club. Mrs. A. J. Antalis of Powhatan Point, president of the Auxiliary, conducted the business meeting preceding the program. Experiences while on a European tour were related by Mrs. L. L. Liggett and Mrs. Harry Harris. At 6:30 p. m. the women joined the Medical Society for dinner.

CLARK

The Woman's Auxiliary to the Clark County Medical Society held a dessert meeting at the home of Mrs. David Hunter on Friday, January 11.

After the business meeting, conducted by Mrs. Martin J. Cook, a very interesting program was presented by Mr. and Mrs. Evan Whallon. The program was entitled "Music and Your Child." Mr. Whallon is conductor of the Springfield Symphony Orchestra and Mrs. Jean Whallon is an instructor at Antioch College at Yellow Springs. Hostesses for the day were: Mrs. Max Gerke, Mrs. George P. Fitzgerald, Jr., and Mrs. Robert Horton.

COLUMBIANA

The difficulties of women entering the field of medicine were discussed by Dr. Edith Gilmore, local physician, at the meeting of the Woman's Auxiliary to the Columbiana County Medical Society on January 15 at the Wick Hotel, Lisbon, following a joint dinner with the doctors.

Dr. Gilmore stressed that women had been active in the medical profession for only 125 years. There are now over 7,000 women practicing medicine in the eastern part of the country alone.

Reports of committees were heard. The group voted to sponsor the countywide Cancer Fund Drive in April.

Appointed to the nominating committee were Mrs. John A. Fraser and Mrs. J. F. Jackson of East Liverpool, and Mrs. C. R. Crowgey of Salem.

Delegates named to the state convention at Columbus in May were Mrs. William J. Horger of East Liverpool, president, and Mrs. Hart with Mrs. W. S. Banfield of Irondale, alternate.

The sum of $25 was given to the March of Dimes. Tentative plans were announced for a "Gardenia Dance" on April 6 at the Country Club.

Mrs. H. F. Banfield introduced the guest speaker.

FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Society met January 14, for a business luncheon in Hotel Lancaster.

Mrs. C. R. Reed, the president, asked for reports from several committees. Mrs. James Beesley and Mrs. Andrew Essman will serve as co-chairmen for the annual Nurses Tea to be held in the Nurses' Home in March.

Mrs. S. C. Sneeringer's report included arrangements for a play, "A Point of Beginning" presented by the Ohio State Family Players and sponsored by the Woman's Auxiliary. P. T. A. groups in the city were invited.

Mrs. Galon Rodabaugh read the new application forms for nurses' scholarships. The Woman's Auxiliary voted to place these scholarship application forms in the city and county high schools. They are for girls interested in a scholarship to the Lancaster-Fairfield Hospital School of Nursing.

Mrs. Reed listed the members of the nominating committee—Mrs. H. M. Amstutz, Mrs. F. E. Spangler, and Mrs. Boice VanGundy.

Hostesses at the January meeting were Mrs. W. D. Nusbaum, Mrs. S. C. Sneeringer, Mrs. Harold Schwendeman, and Mrs. F. A. Dowdy.

HAMILTON

The Cincinnati Club was the scene of the January 15 luncheon meeting of the Woman's Auxiliary to the Academy of Medicine of Cincinnati.

The guest speaker was Dr. David A. Tucker who gave an enlightening talk on the "History of Medicine in Cincinnati." Mrs. Daniel V. Jones, who was assisted by Mrs. Paul N. Jolly, planned this interesting program.

The business meeting was conducted by the president, Mrs. Calvin Warner. Committee reports were given by the historian Mrs. Edgar S. Lotspeich who displayed scrapbooks from past years, and Mrs. Henry Ryder who reported on legislation. Mrs. Robert M. Woolford reported on the Centennial Committee. Mrs. Edgar White, chairman of ways and means, gave the report on the December dance. Mrs. William Kroovand gave the results of the Christmas card project. The results of the election of the nominating committee were announced. The executive board elected from its own members Mrs. Herbert

Brinker and Mrs. Kent E. Martin. The general membership elected the following: Mrs. Arthur Evans, Mrs. John Devanney, Mrs. Daniel Jones, Mrs. John Toepger, and Mrs. Carl Vilter.

The choral group presented appropriate songs from 1850 to 1950, and Mrs. Herbert Brinker presented pins to the past presidents in recognition of their loyal services.

HARDIN

Members of the Auxiliary to the Hardin County Medical Society held a dinner meeting on January 8, in the dining room at Hardin Memorial hospital at which time Mrs. William Binkley, treasurer, gave the financial report of the recent Mistletoe Ball and announced that $1,000 was to be divided between Hardin Memorial and San Antonio hospitals.

Mrs. Floyd Elliot, president of the Auxiliary, conducted the business session which was attended by 15 members.

Tentative plans were made for the annual nurses recruitment tea to be held this year at Hardin Memorial hospital, with Mrs. Robert Zeis and Mrs. Stephen Churchill, co-chairmen, in charge of arrangements for the affair.

The Auxiliary joined the Medical Society to hear the evening's guest speaker, Judge Claude Pettit, who addressed the groups, explaining the functions of the probate and juvenile courts of the county over which he presides.

JEFFERSON

The Woman's Auxiliary to the Jefferson County Medical Society held its January 25 meeting in the home of Mrs. Carl Goll.

A contribution to the American Medical Education Fund was made. It was also decided to sponsor a series of health programs over Station WSTV. They will be based on *Today's Health*.

Mrs. Walter Cunningham and Mrs. Ed Weinman assisted the hostess.

LICKING

The Rev. Harry H. Kruener, professor of religion and dean of chapel of Denison University was the guest speaker for the Auxiliary to the Licking County Medical Society at the dinner meeting, January 29, in the YMCA.

In discussing his personal reflections of polio when it strikes in homes, Rev. Kruener emphasized the different phases the patients and their families enter.

During the business meeting which followed, the Auxiliary decided to make its annual contribution to the American Medical Education Foundation.

LOGAN

Mrs. Charles A. Browning, Jr., entertained members of the Woman's Auxiliary to the Logan County Medical Society January 22 at her home.

Routine business was conducted by Mrs. Doug-

(Continued on Page 350)

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las Beach, president. Mrs. J. P. Harbert read a letter from Mrs. Lorida Wiseman, State Civil Defense chairman of the Auxiliary, cautioning members to pay heed to civil defense and to know exactly what to do in time of disaster.

Mrs. Warren F. Mills, Third District Auxiliary director, reviewed briefly the highlights of the past year and the duties of the various medical auxiliaries and outlined the county auxiliary meetings she had attended and still planned to attend before the fiscal year ends.

The group voted to donate $25 to the American Medical Education Foundation. Plans were made for a valentine party for members and their husbands.

LUCAS

The Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County met on January 8 for luncheon at the Academy Building. Patrolman Smith, of the Perrysburg Post of the State Highway Patrol, spoke and presented a film on "The Woman Driver." There also was a reading of the revisions to the constitution and by-laws of the organization.

This Auxiliary gave a Mother's March on Polio Tea on January 16 in the Academy of Medicine Building.

Elaine Whitelaw of New York, national director of women's activities of the National Polio Foundation spoke. Mrs. Robert Willard was chairman of the tea, with Mrs. Paul Baehren, co-chairman.

MAHONING

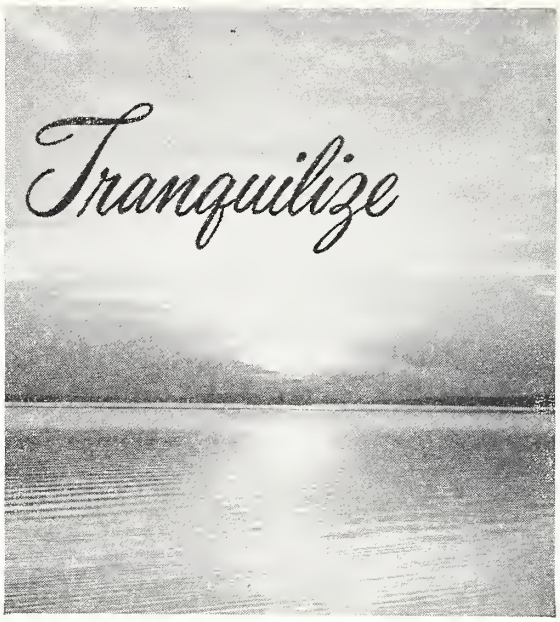
On the January schedule for the Woman's Auxiliary to the Mahoning County Medical Society was the annual midwinter tea for prospective nurses which was held January 15 at the North Side Hospital. Mrs. Paul J. Mahar is president.

All high school girls in the county schools interested in studying for the nursing profession were invited to attend. Miss Murial Dunlap, director of nursing education at North Side Hospital, was the speaker for the students, and the Auxiliary's speaker for the day was George Krispli, chief of the Youngstown police vice squad. His subject was "The Control of Narcotic Traffic in Greater Youngstown."

MARION

The need of an awakening to the need and responsibility of a civil defense program in this and every other community was presented by Thane M. Durey, deputy director of the Civil Defense Corps of Ohio, in a talk before members of the Woman's Auxiliary to the Marion Academy of Medicine, January 15 at Hotel Harding.

During a business session following the talk, the Auxiliary adopted a policy for memorials to be made in the form of donations to the American Medical Educational Fund. Plans were discussed for a series of benefit bridge parties in May to



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be held in the homes of the members. A report was given on the operation of the snack shop at the Marion General Hospital and also on the nurses student loan fund, a major project of the Auxiliary. The program hour was preceded by a luncheon in the Plantation Room.

MIAMI

A luncheon was given at Dettmer General hospital January 8 for the Woman's Auxiliary to the Miami County Medical Society.

The speaker was Dr. George Woodhouse, Councilor of the OSMA Second District and a member of the American Medical Association Judicial Committee, who talked on the structure of the organization, the policies and the efforts made to further medical education. Mrs. E. G. Puterbaugh conducted the business session.

ROSS

State Highway Patrolman John W. O'Neil was guest speaker at the dinner meeting of the Woman's Auxiliary to the Ross County Medical Society, January 3, at the Lynne House.

Patrolman O'Neil showed two movies, "Hit and Run Driver" and "Practice Makes Perfect." He also gave the group pointers on good driving.

Mrs. John Franklin, Jr., program chairman, introduced the speaker. Mrs. Lewis Coppel, president, conducted the business session. Reporting for Mrs. Charles N. Hoyt, she announced the health program sponsored by the Auxiliary—a series of 15 minute broadcasts over WBEX. The broadcasts will continue on each Monday for 13 weeks and will be based on articles from *Today's Health*.

Mrs. L. T. Franklin reported on the brochures the Auxiliary is helping to provide for hospital patients. The brochures list articles needed by patients, visiting hours, baby-showing hours, telephone arrangements, checking in and out procedures, etc.

SUMMIT

Woman's Auxiliary to Summit County Medical Society met in Sanginiti's Restaurant for a luncheon meeting January 8.

Mrs. H. Oliver Musser, president, presided over the business meeting. Gabe Sanders, assistant professor of education at Akron University, was guest speaker. His subject was "A Girl's Best Friend." Professor Sanders was introduced by Mrs. Ruben Pliskin.

Mrs. R. J. Hemphill has set the dates of March 15, 16, 18 for the tenth annual Health Days Exposition. The health days committee includes: Mrs. R. J. Hemphill, chairman; Mrs. J. W. Parks, co-chairman; Mrs. D. E. Banks, Mrs. E. F. Hurteau, Mrs. W. C. Marsh, Mrs. L. V. Phillips and Mrs. R. M. DeWitt.

TUSCARAWAS

In an attempt to give emphasis to Civil Defense and present a knowledge of measures already in effect, members of the Auxiliary to the Tuscarawas County Medical Society met December 11 in the Dover Public Library and had, as the guest speaker, Mrs. Louise Swearingen, administrative supervisor of the Canton Filter Center.

Members of the Auxiliary had as their guests, the wives of Tuscarawas County dentists and druggists.

Mrs. J. W. Hamilton, of Dover, the Auxiliary's Civil Defense chairman, had arranged a table display which featured a kit containing necessary items for first aid and supplies which should be kept in the basement of every home in case of an attack. She told of the Auxiliary's aim for alerting people in this area.

Sgt. James R. Yerkey of the Canton Filter Center showed a color film of the A bomb test and its results.

At the conclusion of the program, buffet refreshments were served. Assisting Mrs. Hamilton in planning the program were Mrs. Max Shaweker and Mrs. Robert Rinderknecht of Dover, and Mrs. M. W. Everhard and Mrs. Paul Hahn.



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American Academy of General Practice To Hold Scientific Assembly in St. Louis, March 25 - 28

Are children's ears and feet neglected? Is a laboratory report always accurate? What's new in the world of tranquilizers? These and hundreds of other important questions will be answered during the American Academy of General Practice Ninth Annual Scientific Assembly, March 25-28 in St. Louis' Kiel Auditorium.

More than 25 prominent physician-authorities will appear on the four-day scientific program. In addition, the more than 5,000 family doctors expected to attend will have opportunities to visit 73 scientific and 260 technical exhibits.

The Academy's policy-making Congress of Delegates will convene Saturday, March 23, in the Gold Room of the St. Louis Sheraton-Jefferson. Delegates from every state, plus Alaska, Hawaii, Puerto Rico and the District of Columbia will meet until noon, Monday, March 25, when they will attend scientific sessions in the auditorium.

The Assembly is a vital part of the Academy's postgraduate study program. The Academy requires continuing postgraduate study as a membership requirement. Every three years, each member must complete 150 hours of accredited postgraduate work.

At 8:30 a.m. Monday, March 25, physicians will start registering for the four-day scientific session. Opening ceremonies at 1:00 p.m. Monday include a call to order by Academy President Dr. John S. DeTar, Milan, Mich.

The first Monday p.m. session highlights the advantages and results of maternal mortality studies. Three authorities will compare notes during the 90-minute panel session. The three are Drs. Ralph A. Reis, Northwestern University; Harold S. Morgan, University of Nebraska; and Willis E. Brown, University of Arkansas.

At 4 p.m., Drs. Thomas V. Geppart, University of Wisconsin, and Irwin H. Kaiser, University of Minnesota, will discuss the dangers that face the newly-born infant. Emphasis will be on respiratory complications.

Tuesday morning the spotlight will shift to the "neglected medical areas" of childhood and adolescence. Details may be obtained from the American Academy of General Practice, Volker Blvd. at Brookside, Kansas City 12, Mo., or the Ohio Academy of General Practice, 209 So. High St., Columbus 15.

The Southwestern Ohio Society of General Physicians and the Ohio Committee on Trauma of the American College of Surgeons held a seminar on "Trauma" at the Hartwell Country Club on January 20. The program was in collaboration with the University of Cincinnati College of Medicine. The next seminar will be held on March 17 when the subject will be "Radiology and Radio-Isotopes."

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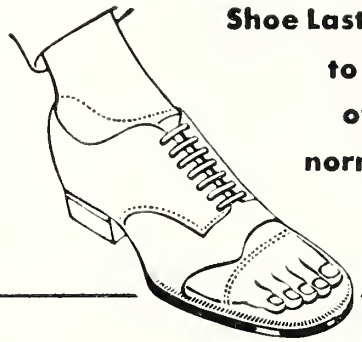
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New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since January 2, 1957. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ATHENS COUNTY
William E. Sprague, Athens

BUTLER COUNTY
Richard H. Mense, Hamilton

CLARK COUNTY
George P. Anderson, Springfield

COSHOCTON COUNTY
John L. Magness, Coshocton

CRAWFORD COUNTY
Gerald E. Blanchard, Galion

CUYAHOGA COUNTY
John D. Gerlach, Cleveland
Donald R. Lyon, Chagrin Falls
Irwin N. Perr, Cleveland
Franklyn J. Simecek, Cleveland
Herbert L. Weininger, Cleveland

DELAWARE COUNTY
Henryk Bergman, Delaware
Francis W. Logan, Delaware
William L. Vogt, Delaware

ERIE COUNTY
Edward Gillette, Sandusky
Lawrence F. Kienle, Sandusky

FULTON COUNTY
Paul E. Cooley, Swanton
Robert W. Nyce, Fayette

GEAUGA COUNTY
George Dandalides, Chardon
Samuel K. McHutchison, Burton

GUERNSEY COUNTY
Jesse B. Kellum, Cambridge
A. Clifton Smith, Jr., Cambridge

HENRY COUNTY
Robert L. Ullum, Liberty Center

HURON COUNTY
Richard L. Jackson, Willard

LOGAN COUNTY
George Gensemer, Bellefontaine

LUCAS COUNTY
Warren Nordin, Toledo
Martin Reiner, Toledo

MAHONING COUNTY
Irving Berke, Youngstown
Raymond S. Boniface, Youngstown
Alexander Calder, Youngstown
Aniceto DiDomenico, Struthers
Donald R. Dockry, Youngstown
Leonard F. Fagnano, Youngstown
John G. Guju, Youngstown
Bertram Katz, Youngstown
Jack Malkoff, Youngstown
Joseph V. Newsome, Youngstown
Robert W. Parry, Youngstown
George B. Pugh, Youngstown
Louis H. Scharf, Youngstown
James R. Sofranec, Youngstown
Salvatore Squicquero, Youngstown
Kurt Wegner, Youngstown

MEDINA COUNTY
Harry E. Hartmann, Valley City

MONTGOMERY COUNTY
Bruce F. Andreas, Dayton

MUSKINGUM COUNTY
Gordon E. Gifford, Zanesville

OTTAWA COUNTY
Heinz A. Boker, Put-In-Bay
Paul K. Ridenour, Elmore

PICKAWAY COUNTY
Francis W. Anderson, Circleville

PUTNAM COUNTY
James E. Baker, Leipsic
David A. Barr, Lima

ROSS COUNTY
Joseph McKell, Chillicothe

STARK COUNTY
Arthur J. Abelson, Canton
Stanley Benjamin, Canton
Viljams Blumentals, Canton
Reita M. Bussan, Canton
Robert J. Bussan, Canton
William K. Cotton, Canton
Robert F. Feltman, Canton
Aubrey R. Furnas, Jr., Massillon
Terrance D. Furness, Canton
Edward E. Grable, Canton
Joseph K. Gyalai, Canton
Mansell B. Holmes, Massillon
Dragoljub S. Jevrem, Canton
Guy T. Milazzo, Canton
Jack G. Miller, Alliance
Alan Raftery, Canton
Frederick J. Raisch, Canton
Ernest A. Turpin, Jr., Massillon

SUMMIT COUNTY
Edward F. Morris, Barberton

TRUMBULL COUNTY
Robert J. Paul, Niles
Kazimierz P. Swisterski, Warren

More Than $4 Million Goes to Medical Schools from AMEF and NFME

The nation's 83 medical schools received a total of $4,139,827 on February 11 from the American Medical Education Foundation and the National Fund for Medical Education. The AMEF provided $1,072,727, contributed by individual physicians, medical organizations and woman's auxiliaries. The amount distributed by the NFME totalled $3,067,100, made possible by donations from corporations and individuals plus some matching money from the Ford Foundation.

Amounts received by Ohio's three medical schools in the February 11 distributions and totals they have received since 1951, follow:

Ohio State University College of Medicine: AMEF, $12,767.50; NFME, $51,855; total since 1951, $207,962.77.

University of Cincinnati College of Medicine: AMEF, $12,308.78; NFME, $36,905.00; total since 1951, $172,136.22.

Western Reserve University School of Medicine: AMEF, $9,500.50; NFME, $35,735; total since 1951, $166,643.53.

The total amount raised by the American Medical Education Foundation in 1956 was $1,072,727.00 from 39,892 contributors. The Ohio AMEF campaign produced $27,724.78 from 587 donors. Included in that amount was $8,443.53 from woman's auxiliaries throughout the state.

Figures are not yet available on the amounts contributed by physicians directly to their own medical schools through alumni funds.

Medical Education Week Programs Scheduled for April 21-27

A "week" of more than ordinary importance will be celebrated during the April 21-27 period. It is Medical Education Week, and the sponsorship includes the American Medical Association, the Association of American Medical Colleges, the National Fund for Medical Education and other such organizations.

For the benefit of those planning local promotion of this all-important subject, the American Medical Association has sent kits of material to officers of all County Medical Societies. These kits include promotional material suggestions for radio and television, newspapers, civic organizations, special programs, Woman's Auxiliaries, proclamations of local officials and other community contacts.

The "week's" general purpose is to develop public understanding of the aims, problems and progress of medical education.

Dr. William R. Havener, Department of Ophthalmology, Ohio State University, will participate in a panel discussion on diseases of the ocular fundus during the Fourth Interim Congress of the Pan American Association of Ophthalmology in New York City, April 7-10.

Ohio Medical Assistants Plan Get-Together in April

The Medical Assistants Society of Toledo and Lucas County, the Summit County Medical Assistants Society, and the Medical Assistants of Cincinnati are jointly sponsoring a meeting of all interested personnel of the offices of the doctors of Ohio for the purpose of forming a state society of medical assistants.

This meeting will be held in Toledo on Saturday and Sunday, April 27 and 28, 1957.

Those interested may wish to secure more information from Miss Ruth M. Walkowiak, 424 West Woodruff Avenue, Toledo 2. Co-chairmen of the project are: Miss Jane Hoy, Akron, and Miss Jean Reib, Cincinnati.

Uniform Labeling Study Launched by AMA

Physicians of Ohio will be interested in a program to protect the public from the dangers of mislabeled household and commercial chemicals launched recently by the AMA.

Through its Committee on Toxicology, the AMA is gathering information on existing state labeling regulations with the idea of developing model legislation on the precautionary labeling of various chemical products, such as paints and paint removers, heating and cooking fuels, household polishes and cleansers, laundering items, etc., not now subject to regulation.

Bernard E. Conley, Ph. D., committee secretary, reports that such organizations as the American Academy of Pediatrics, American Public Health Association, American Pharmaceutical Association, National Safety Council, leading trade associations and various state and national governmental regulatory agencies are being consulted on this problem and its solution.

COMING MEETINGS

1957 Annual Meeting, Ohio State Medical Association, Columbus, May 14, 15 and 16.

American Medical Association, Annual Session, New York City, June 3-7.

American College of Surgeons, Course on Fractures, Chicago, April 10-13.

Law-Medical Center, "The Heart: a Law-Medicine Problem," Cleveland, March 22-23.

Medical Education Week, April 21-27.

National Health Forum, Netherland-Hilton Hotel, Cincinnati, March 20-22.

Northern Tri-State Medical Association, Annual Meeting, Toledo, April 11.

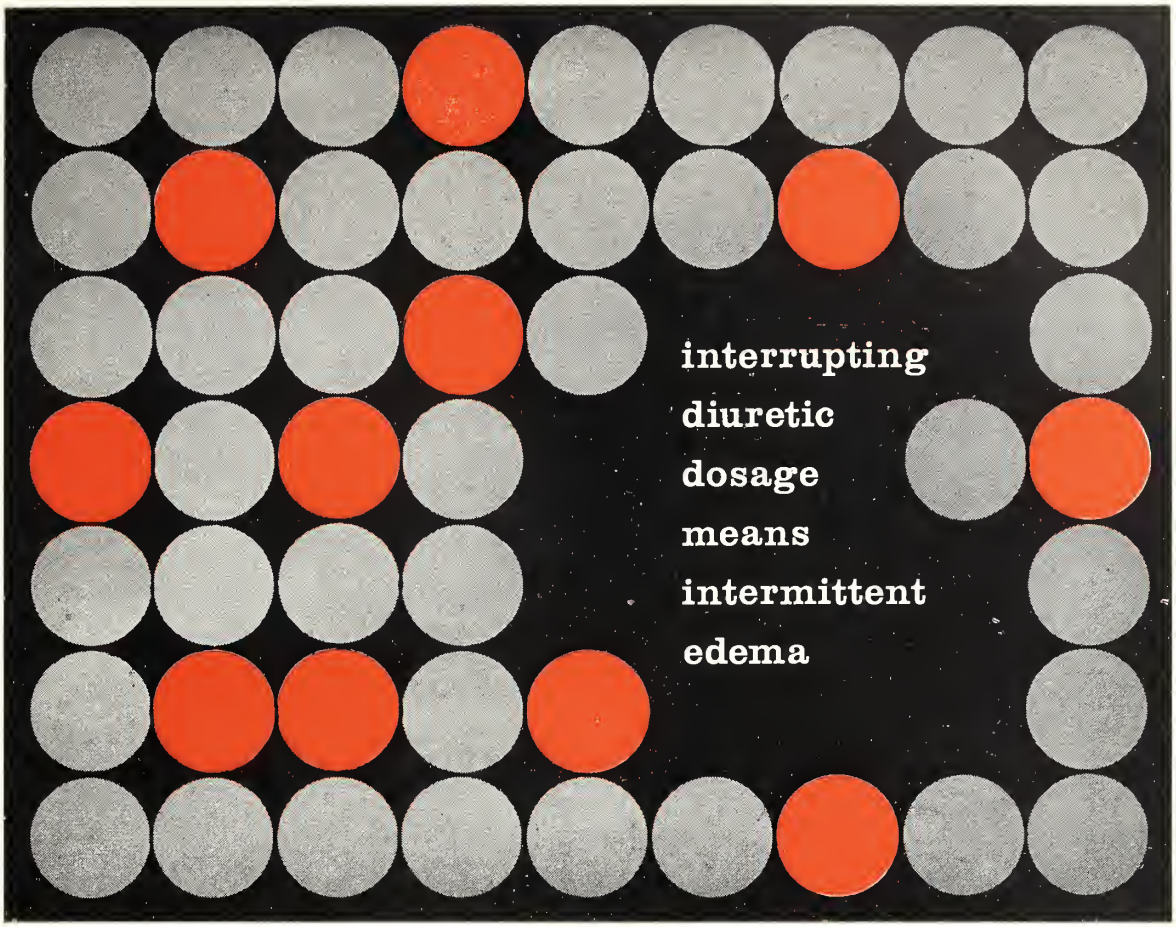
Ohio State University Medical College Alumni, Reunion, Columbus, April 27.

Seminar on Venereal Disease, Dayton, April 17.

Veterans Administration Clinical Conferences, Cleveland, weekly on Wednesdays.

INDEX TO ADVERTISERS

Abbott Laboratories	274 - 275
American Meat Institute	258
American Medical Association	369
Ames Company, Inc.	358
Ann Arbor School	352
Appalachian Hall	260
Ayerst Laboratories, Inc.	338
Bayer Company, The Div. of Sterling Drug Co., Inc.	267
Burroughs, Wellcome & Co., (U.S.A.) Inc.	333, 337, 356
California State Personnel Board	355
Ciba Pharmaceutical Products, Inc.	368
Cincinnati Sanitarium	(See *North*)
Columbus Pharmacal Company	257
Cook County Graduate School of Medicine	339
Davies, Rose & Co., Ltd.	272
Ethicon, Inc.	273
Flint, Eaton & Company	366
Foot-so-Port Shoe Company	352
Geigy Pharmaceuticals, Inc.	362
General Foods Corporation (Sanka)	264
Harding Sanitarium	335
Hoffmann-LaRoche, Inc.	Insert between pages 324 - 325
Knox, Chas. B., Gelatine Co., Inc.	255
Lakeside Laboratories, Inc.	253
Lederle Laboratories	Insert Between Pages 316-317; Pages 341, 345
Lewal Pharmaceutical Company	370
Lilly, Eli, and Company	280
Lloyd Brothers Inc.	364 - 365
Mallard, Inc.	350
Medical Protective Company	347
Merck Sharp & Dohme	269, 348-349, 360 - 361
Neil Training School	355
New York Polyclinic Medical School	278
North, Emerson A., Hospital, The	329
Parke, Davis & Company,	372 and Inside Back Cover
Pfizer, Chas. & Co., Inc.	271, 276-277, 363
Pogue, Mary, School, Inc.	342
Quincy X-Ray & Radium Lab	344
Riker Laboratories, Inc.	359
Robins, A. H., Co., Inc.	339, 343, 347, 367
Sawyer Sanatorium	261
Schering Corporation	279
Scroggins, Clayton L., Associates (Medical-Dental Management)	265
Searle, G. D., & Company	327
Smith, Kline & French Laboratories	331, 357, and Back Cover
Squibb, E. R., & Sons, Division of Olin-Mathieson Chemical Corporation	371
Stoneman Press	335
Tutag, S. J., & Company	278
U. S. Vitamin Corporation	262 - 263
Wallace Laboratories	259
Wendt-Bristol Company	343
Windsor Hospital, Inc.	351
Winthrop Laboratories	260, 265
Year Book Publishers, The, Inc.	270



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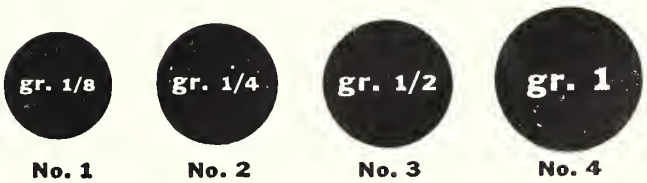
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Dynamics of Clinical Instruetion in Nursing Edueation, edited by Mary Grace Gabig, R. N., and Barbara T. Lanigan, R. R. ($3.50. *The Catholic University of America Press, Washington 17, D. C.)* This is the proceedings of a workshop on the subject conducted at the Catholic University of America. The theme of 23 topies considered was that clinical instruetion is the heart of nursing education. The goal of all instruction is better patient care. These deliberations of 169 nurses from 28 states has been crystalized into a worthwhile book.

Anesthesia for Obstetries, by Robert A. Hingson, M. D., and Louis M. Hellman, M. D. ($12.50. *J. B. Lippincott Co., Philadelphia 5, Pa.)* This book gives eomplete coverage of a subject receiving more and more attention from those interested in lowering maternal and infant mortality. All the problems of anesthesia–obstetries have been covered from abortion to x-rays. The special chapter on Maternal and Infants Safeguards written by Virginia Apgar, M. D., is outstanding. It is a long way from the first delivery under anesthesia on January 19, 1847, to the advice given in this book. **Anesthesia for Obstetries** is a book which should be in the interns' library of every hospital and in the hands of each member of every Committee on Maternal and Infant Mortality and Morbidity.

The Menninger Story, by Walker Winslow. ($5.00. *Doubleday and Co. Inc., Garden City, New York.)* This is a biography of Dr. Charles Frederick Menninger and the story of the Clinic which he founded. Inspired by a visit to Rochester, Minnesota, the elder Menninger decided that his sons should study medicine and with him found a clinic in their home town of Topeka. With the help of his good wife he succeeded in doing just those things. For anyone interested in the history of American medicine; in group practice; in the success story of a determined man and his wife, this will prove an interesting tale. To those concerned about our mental hygiene problem the development of this world famous clinic for the training of psychiatrists and the treatment of the institutionalized mentally ill, this book is a must.

Hunza: Lost Kingdom of the Himalayas, by John Clark. ($5.00. *Funk and Wagnalls, New York 10, N. Y.)* Here is a lesson for all of us not to go around quoting unusual conditions in far-off peoples of a different culture. For years we have been told about the robust eharacter of these people. Colonel Garrison's observations of his pack-train men were no doubt aceurate but he must have neglected the rank and file of the people. Clark, a geologist exploring the country, tells in his book an entirely different story of a disease-ridden people.

Rodale on the basis of the Colonel's observation and his correspondence with the ruler of the Hunza has been using these people as a model of what a primitive diet can do for a people. So what the heathen Chinee and other faraway peoples have or do not have in the way of disease should not be used to draw deductions from and establish rules of health.

The Offiee Assistant in Medical and Dental Practice, by Portia Frederick and Carol Towner. ($4.75. *W. B. Saunders Co., Philadelphia 5, Pa.)* A 1952 survey of 5,000 physicians revealed that the physician who employs one or more aides spends 40 per cent less time per patient than one who works alone. Since 65 per cent of physicians employing help have only one girl, she should be trained to do many things both in office assistance and in secretarial work. This text will help her greatly to perform her manifold duties in a more efficient manner.

Obstetrie Practice, by Harold Speert, M. D., and Alan F. Guttmacher, M. D. ($7.00. *McGraw-Hill Book Co., Inc., New York 36, N. Y.)* This is another in the new series of handbooks for the general practitioner. As the title indicates it is a praetical, up-to-date guide to assist the physician in the actual care of his obstetrical patient.

The Complete Book of First Aid, by John Henderson, M. D. ($3.50. *Little, Brown & Co., Boston 6, Mass.)* The medical director of Johnson and Johnson has given us a new and complete manual of practical first aid. It offers not only approved information on the emergency treatment of accidents but also on the recognition and emergency treatment of the more common illnesses.

Proeeedings: The Institute on Rehabilitation Centers. ($1.60. *National Society for Crippled Children and Adults Inc., Chicago 3, Ill.)* This is a compilation of papers which make up a wise and authoritative manual for administrators and other professional rehabilitation workers to help the handicapped.

Geneties is Easy, by Philip Goldstein. ($4.00. *Lantern Press, New York 10, N. Y.)* The first edition was a sellout and so we now have a revised and enlarged edition to include the new concepts of heredity.

The Normal Child, by C. W. Valentine. ($0.85. [A Pelican Book] *Penguin Books Inc., 3300 Clipper Mill Road, Baltimore 11, Md.)* This is a

well written introduction to child psychology with special references to individual differences often mistaken for abnormalities. Here one of the leading authorities in the field debunks so much of the hogwash that has appeared in print in recent years.

Cerebral Palsy: Its Scope and Management, by Marguerite Abbott. (25 cents. *Public Affairs Pamphlets, 22 East 38th Street, New York, New York.)* This booklet, No. 158 A of Public Affairs Pamphlets, is designed to point up some of the broad concepts and the ways in which cerebral palsy is currently being handled.

Mental Hygiene: The Dynamics of Adjustment by Herbert A. Carroll, Ph. D. ($6.50. 3rd edition. *Prentice Hall Inc., Englewood Cliffs, N. J.)* The reception which this text has had speaks for itself. The author goes to the heart of the problem telling of the need for physical security, emotional security, status and achievement. He shows his reader how learning takes place, how problems are solved and about the repressions and inhibitions induced by anxiety.

Genetics in the Atomic Age, by C. Auerbach, Ph. D., D. Sc. ($2.00. *Essential Books Inc., Fair Lawn, N. J.).* There seems to be a desire on the part of certain bureaucrats to silence those scientists who are concerned with the great importance to use atomic energy with scrupulous care and the best of protective measures if unborn generations are not going to pay an enormous price for our folly. The development of plants near large centers of population is one of the current dangers. In this book a member of the staff of the Institute of Genetics in Edinburgh explains mutations, how they may be produced by atomic energy and what they may be like.

I Have Six Wives, by Samuel W. Taylor. ($3.75. *Greenberg Publisher, New York 22, N. Y.)* The author of **Family Kingdom** tells the story of a man who defied the laws of the state, his church and public opinion to marry six wives in polygamy and to father as many children as possible in this modern day of television and income tax. This is a true story of present-day plural marriage and gives some insight into the "fundamentalists"—of a man and six lovely girls who chose to dedicate their lives to a lost cause.

Facts of Life and Love for Teen-Agers, by Evelyn Millis Duvall. ($3.50. Revised Edition. *Association Press, New York 7, N. Y.)* It gives the facts with dignity. It is by one of the nation's foremost counselors who knows the questions that are troubling the Junior High and High School youths of today.

The Management of Menstrual Disorders, by C. Frederick Fluhmann, M. D. ($8.50. *W. B. Saunders Co., Philadelphia, Pa.)* The author has brought out a new discussion of the subject some 17 years after his first. In the meantime there has been many fundamental discoveries and what is even more important a reappraisal of the anatomic and physiologic changes in the menstrual cycle and its disorders, refinements of many diagnostic and therapeutic procedures and a sounder evaluation of the role of the endocrine factors.

Human Heredity Handbook, by Amram Scheinfeld. ($3.95. *J. B. Lippincott, Philadelphia 5, Pa.)* The author of **You and Your Heredity** presents the answers as science now gives them to questions with which we are all concerned. The book is intended for physicians, marriage counselors, teachers, and parents.

Essentials of Dermatology, by Norman Tobias, M. D. ($8.00. Fifth Edition. *J. B. Lippincott, Philadelphia 5, Pa.)* The author has written a practical dermatologic book of reference for busy practitioners with all of the unnecessary detail eliminated and the emphasis placed on differential diagnosis and treatment.

A Doctor's Apprenticeship, Dr. Benzion Liber. ($5.00. *Rational Living, 65 W. 95th St., New York 25, N. Y.)* A fascinating autobiography of a kindly humble physician to whom many of the great and the near great have paid homage, gives an excellent picture of Paris, Vienna, and New York for the past 80 years.

Pulmonary Carcinoma, edited by Edgar Mayer, M. D., and Herbert C. Maier, M. D. ($15.00. *J. B. Lippincott Co., Philadelphia 5, Pa.)* Forty-four years ago when I first encountered specimens of lung cancer at the autopsy tables we turned to Adler's monograph with its some 300 reported cases. Today more cases than that can be found in any one of our larger cities within one year. The editors with more than a score of investigators have produced a practical volume giving us the last word from men of great experience.

Genetics Notes, by James F. Crow. (Second Edition. $3.00. *Burgess Publishing Co., Minneapolis 15, Minn.)* This notebook has the laudable purpose of supplying the student with the equivalent of a set of notes so that the student doesn't have to scribble his own during the class period. Most of us cannot think and write at the same time and so a book of this sort would be a godsend wherever lectures are given. The professor of genetics and zoology at the University of Wisconsin is to be congratulated on his cooperation in this matter and on the fact that he sets the stage by introducing the history of genetics in the first three chapters. More teachers, especially in medical school, could well pay more attention to the historical background of their subject. As it is, most medical men are ignorant of whence they came and therefore are unable to project themselves into the future. They seem cock-sure that nothing worthwhile happened in medicine before 1920.


SAFETY FIRST

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Treatment of Psychomotor Epileptics with Reserpine

CARL M. ROSENBERG, M.D.

OUT of a group of 71 institutionalized epileptic female patients 19 were selected who had been the most difficult to manage. They all had clinical grand mal and psychomotor seizures, one also frequent petit mal attacks. For six months and longer they had exhibited the same individual pattern of convulsions and behavior under an unaltered medication which consisted of various dosages and combinations of dilantin,® phenobarbital, mysoline® and mesantoin.® This routine medication was maintained without change through the experiment. Reserpine was added to each patient's routine anticonvulsant drugs and administered only orally.* The usual daily dose was 2 mg. The actual range was from 0.25 mg. to 8 mg. per day.

CONTROL GROUP

A control group of 30 patients, grand mal, and some grand mal and petit mal, or grand mal and psychomotor, but all with much less serious behavior problems than the experimental group, were kept on their routine medication under which their seizures had remained practically unchanged for at least three months. But some of the women in the control group had to be treated with larger doses or different kinds of anticonvulsants during the period of the study when their convulsions increased.

The experimental group was selected regardless of history, etiology and length of illness. Ages ranged from 23 to 63 years, averaging 37.5 years. The observation ran five months; in one case six months, in another case seven months.

FINAL EXPERIMENTAL GROUP

The medication of one patient, whose convulsions and psychosis remained unchanged after two months of treatment, was discontinued. In her case no EEG (electroencephalogram) was obtainable. Medication of another psychotic patient who did not show any changes in convulsions but became somewhat quieter was discontinued because she took the rau-sed® very irregularly and very seldom; in fact we never were sure whether she took any kind of medicine. Her EEG showed psychomotor discharges on the left.

In a third patient, also with EEG psychomotor on the left, medication was discontinued after four months when convulsions, self-accusations and so forth remained unchanged. A fourth patient, with schizophrenic behavior, became even more withdrawn after four months of treatment. She also was taken off reserpine especially, since

Submitted May 3, 1956.

*The drug used was Rau-Sed,® supplied by the Squibb Institute for Medical Research, New Brunswick, N. J.

The Author

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also in her case we could not be sure whether she took medication at all.

EEG FINDINGS

The EEG of the remaining 15 women showed psychomotor focus in the left anterior temporal in 6 cases, in the right anterior temporal in 1 case, and in both anterior temporals in 3 cases. In 1 case the EEG was of high frequency and low voltage, in 2 others there was slowing with very few spikes, and in the 2 last ones multiple spikes, especially in the biparietals, and diffuse spiking respectively. In none of the tracings were any changes found which could be attributed to the use of reserpine.[1, 2, 3]

EFFECT ON CONVULSIONS

Since it has been shown that in animal experiments reserpine eventually lowered the threshold for convulsions,[4] an improvement in number and severity of convulsions was not expected. However, we found actual improvement in 10 of the 15 patients who remained under reserpine treatment for five months and longer, that is in two thirds of the cases, whereas the ratio of improvement in the control group for the same time was only one sixth of the number of the group, and that although some of the control group had to have their anticonvulsant medication readjusted, as previously mentioned.

Even if we take the entire experimental group of 19 into consideration, improvement in convulsions would have occurred in one half of the cases, or three times as many as in the control group. In 5 patients of the experimental group the convulsions remained unchanged, among them 1 whose convulsions had diminished twice but finally settled to the same number as before the administration of reserpine. The improvements in convulsions consisted of:

In 3 cases—reduction of number.
In 1 case —reduction of number and severity.
In 1 case —reduction of number of grand mal, but petit mal and psychomotor persisted as before.
In 3 cases—reduction of length and severity.
In 1 case —disappearance of postconvulsive confusion.
In 1 case —disappearance of postconvulsive tiredness.

(See table 1)

Reduction of the number of convulsions, especially in jacksonian epilepsy, has been observed by other investigators, allowing reduction in anticonvulsive drugs.

CASE HISTORIES

One woman, *Case 9*, whose convulsions were reduced in number, ceased to have rages of violence, before her convulsions which had served as a kind of warning, and had less headache afterwards. Another one had no more temper rages before and after convulsions. She also stopped her abusive language, threats to others, threats of suicide, and was described by the personnel as jolly. Six of the women had been very aggressive, had had fights frequently, some of them daily; they became peaceful and cooperative. In one of these six, her depressive mood did not change; whereas in another it improved considerably.

Case 7—a 63 year old lady, had been withdrawn, suspicious and accusing. She had not been wanted at the Occupational Therapy Department for over one year on account of her attitude. After reserpine she took her meals with others, laughed with them, was happier than in many years and was working again at the O. T.

Case 8—a 49 year old woman who had had daily spells of crying and of self-accusation, had only one crying spell during a full month and stopped self-accusing entirely.

Case 10—a 29 year old patient, had believed that she was hated by everyone and in turn she had hated every other person, including her parents whom she did not trust. In previous years she had gone on vacation only reluctantly. After only two weeks of reserpine she exhibited no hatred any more and no moodiness. This was an unusually quick reaction to medication. She had only one relapse into her former attitude and only for one day. After three months of reserpine she was looking forward to the visit of her parents, went home with them in eager and joyful anticipation. At home her treatment was continued with undiminished success.

Case 5—a 28 year old girl whose convulsions became milder and shorter, stopped arguing after attacks.

Case 15—a 52 year old woman who required the largest dose of reserpine (8 mg. per day), used to fly into a rage at the slightest provocation, even imagined ones. After reserpine she became able to laugh at rather serious provocations. She noticed herself that for the first time she was listening to what others said and to her own talking which previously had been a presentation of flights of ideas. Now she would stick to one subject and eventually argue intelligently and graciously.

EFFECT ON ATTITUDE OF THE GROUP AND OF THE UNIT

There were others who made this self-observation of their improvement in the mental and emotional field, and who remarked on it. In all, we had 11 women who, for the first time in the memory of the personnel, became open to reason and subsequently susceptible for psychotherapy.

All 15 women whose treatment was not discontinued became more sociable in varying degrees with very infrequent relapses. Some for the first time became helpful to others. One girl stopped stealing. The work of some of them was done in a neater way than ever before, and the ward was cleaner. Abusive and filthy language, the rule before reserpine, was practically not heard any more. Previously, restrictions to the maximum security ward of one or more girls occurred every second to third day. During five months of reserpine we had only one such restriction. No property was destroyed, as had occurred quite frequently prior to the trial period.

In general, there was gradually created such a friendly, congenial atmosphere that it influ-

TABLE 1. RESULTS OF TREATMENT WITH RESERPINE IN AN EXPERIMENTAL GROUP OF NINETEEN PSYCHOMOTOR EPILEPTIC PATIENTS

Case	Age	EEG	Changes in Convulsions	Changes in Behavior and Mentation	Improvement in Convulsions	Mentation Improvement	Maximum Daily dose	Remarks
1	40	Not obtained	Unchanged	Psychosis unchanged			2 mg.	Discontinued after 2 months.
2	49	Ps. M.* left	Unchanged	Psychosis, quieter			4 mg.	Refused to take medicine.
3	50	Ps. M. left	Unchanged	Psychosis with self-accusation unchanged			2 mg.	
4	30	Generalized spike, spike and slow wave.	Unchanged	Psychosis: withdrawn, aggressive, unchanged.			2 mg.	Discontinued, after 4 months.
5	28	Ps. M. bil.	Shorter, milder	No arguing after seizure, less fighting, open to reason.	+	+	2 mg.	
6	28	Ps. M. left	Milder	Much improvement; then a partial relapse in relation to others. Open to reason.	+	+	1 mg.	
7	63	Ps. M. left	Unchanged	Sociable, not accusing, happy. Open to reason.		+	2 mg.	
8	49	Ps. M. left	Lighter; without post-convulsive confusion.	Only one attack of crying and self-accusation (Daily before Reserpine). Open to reason.	+	+	2 mg.	
9	50	Slowing in bifrontals.	Less convulsion; less headache afterwards.	No abuse and violence any more. No change of mood. Open to reason.	+	+	1 mg.	Stopped acts of violence before convulsions, which had served as a warning.
10	29	Fast, low amplitude	Reduced from 13 to 8 per month.	Gave up ideas of reference. Became trusting and happy. Open to reason.	+	+	2 mg.	
11	31	Ps. M. left	Not tired after convulsions	Not so moody; helpful and agreeable. No fights.	+	+	2 mg.	
12	29	Some spike and wave diffuse. Slow	After initial improvement, back to severe convulsions.	Quiet, steady, clean. Open to reason.		+	2 mg.	
13	34	Ps. M. right	No change.	No fights, happier. Open to reason.		+	2 mg.	
14	31	Ps. M. left	Less and lighter.	No abuse, no stealing. Open to reason.	+	+	2 mg.	
15	52	Ps. M. bilateral	Less.	No attacks of violent mania. Open to reason.	+	+	8 mg.	
16	27	Multiple spikes in both parietals.	G.M.** down to half; P.M.*** and Ps. M. unchanged.	More sociable. Open to reason.	+	+	2 mg.	
17	44	Diffuse spikes.	Unchanged	Gave up suicidal threats and rages.		+	2 mg.	
18	26	Ps. M. left	Unchanged	Slightly better disposition and behavior.		+	2 mg.	
19	23	Ps. M. bilateral	Lighter	Schizo improved; friendlier.	+	+	4 mg.	

Ps. M.*—Psychomotor.
G. M.**—grand mal.
P. M.***—petit mal.

enced the social and emotional reactions of all the other patients, including those of the control group. Behavior difficulties in these larger groups had arisen most frequently as reactions to the provocative actions of the experimental group. Because managing these psychomotor epileptics had been too great a strain on her, the matron of the unit had decided to quit the service. After the remarkable change brought about by rau-sed,® she was enthusiastic to continue her work.

TIME FACTOR

The time for reserpine to take effect varied greatly. One 23 year old girl with schizophrenic attacks showed improvement only after four months of treatment. Then she became friendlier and her schizophrenic attacks shorter and less intense. Neither the time necessary for effect nor the way of the response had any correlations in the EEG findings.

Various fields of improvement were, of course, overlapping. A 28 year old girl showed coopera-

tion for the first time, stopped much of her loud senseless arguing after only two days of treatment. After about four weeks, however, she relapsed into an attitude worse than that exhibited before reserpine. But very gradually she improved again considerably and permanently, though never quite to the level of the first acute favorable response. It appears that the turbulent phase which sometimes has been observed as an initial reaction to reserpine,[5] had in this case appeared as a secondary reaction after the initial calming down.

Whether the occurrence of an initial turbulent phase has any bearings on the final response and its permanency cannot be determined at this stage. Besides the just mentioned case, there were two patients who exhibited transient excitement, one of them being the patient whose schizophrenic attacks began to improve only after four months of treatment.

TOXIC SIDE EFFECTS

No alterations of blood pressure, no bradycardia were observed. There were no complaints of dizziness or nasal stuffiness, no signs of parkinsonism. One woman performed her work markedly slower than before. This fact, however, was outweighed by her now reasonable devoting to her tasks all the time which previously had been consumed by irrational arguing and fighting. Another one, who had been slow and lazy previously, became even somewhat slower but in general quieter, steadier, and responsible. One girl, although getting more sociable and more open to reason during most of the day, retained some insolence toward employees, displaying an overbearing attitude and using profanity only in the morning, even to somewhat greater extent than before treatment.

As mentioned in the beginning, one patient, 30 years old, schizophrenia, hebephrenic type, was markedly more depressed and withdrawn after four months of rau-sed,® 2 mg. per day; the medication was then withdrawn. On the other hand we cannot be sure that this patient actually swallowed the tablets. There were no changes of the EEG pattern while the patients were under the influence of reserpine. This fact has been reported by other observers.[1-8]

COMMENT AND SUMMARY

Noce, Williams and Rapaport state that "the longer reserpine is employed, the better the chance."[7] Reserpine appears to have a cumulative effect similar to digitalis.[8] We are now of the opinion that we would have had at least a limited success in some of the four discontinued cases if we had not stopped their treatment so early.

Out of a larger group of female epileptic patients, 19 as the most difficult to control, were selected for a trial treatment with reserpine. All of them had grand mal and psychomotor attacks clinically. The EEG of 12 (63 per cent) showed anterior temporal lobe foci. In four cases treatment was discontinued, after two months and four months respectively. All the remaining 15 patients showed improvement in the area of behavior and mentation (100 per cent), or of the original total of 19 patients, 79 per cent. Ten of the 15 remaining on treatment showed improvement in the area of convulsions (66 2/3 per cent), or of the original number, 52.6 per cent.

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KEEPING UP WITH MEDICINE

• THE IMPORTANT FACTOR in contracting clinical histoplasmosis is being exposed to *H. capsulatum* in recently stirred-up dust which can be inhaled rather than that lying around undisturbed.

* * *

• THERE HAS BEEN a 12-fold increase in lung cancer in the United States since 1930.

* * *

• ACCORDING to Simpson and Hunter, isoimmunization is associated with endocrine disturbances of placental origin resulting in adrenocortical deficiency which interferes with the physiologic hypercorticism of pregnancy. The aim of antepartum use of ACTH and cortisone is to assist the fetal organism to overcome the hypercorticism accompanying isoimmunization, especially during the last trimester.

* * *

• THE LIVER is the central organ of protein metabolism. Protein malnutrition is intimately connected with pathological alterations of the liver.

* * *

• THE NUMBER of cases of infectious syphilis and total syphilis have increased in the United States for the first time since 1948, the increase in total syphilis for the entire country being 4,144 cases.

* * *

• THE GENERAL IMPRESSION is that C. albicans is usually pathogenic for women as well as for mice and is the most common pathogenic fungus found in the vagina but that the infection can be asymptomatic.—J. F.

Drug Therapy of Hypertension—A Report Of a New Agent, Ecolid®*

BERNARD H. MARKS, M.D.; PAUL RADETSKY, M.D., and D. J. VINCENT, M.D.

FOR the modern medical management of arterial hypertension, drug research has made available a large, and often confusing, variety of therapeutic agents. None of them are specific therapeutic agents for the disease, in that they are capable of lowering the blood pressure of normal as well as hypertensive individuals. Futhermore, it seems questionable that any of these drugs attack the basic cause of the disease process and it is not yet certain that they influence the long-term outcome of the disease. Nevertheless, it seems desirable to practitioners to use whatever means are available to lower the arterial pressure and drugs continue to play a prominent part in this effort.

In general, the drugs used for this purpose fall into several distinct pharmacologic classes, although some drugs may act at more than one site: (1) sedatives; (2) drugs acting on the vasomotor center or vasomotor reflexes; (3) drugs acting directly on blood vessels; (4) sympatholytic and adrenolytic drugs; (5) ganglionic blocking drugs.

DRUGS ACTING CENTRALLY

Among the sedative agents are both the oldest and the newest drugs used in medicine for the management of hypertension. Acting at the emotional level, such agents as the long-acting barbiturates sometimes achieve a satisfactory result. More frequently they are utilized as adjuncts to the use of more potent drugs.

Reserpine and other derivatives of Rauwolfia root have sedative and tranquilizing properties that aid in the control of the emotional component of hypertension. In addition, this alkaloid may act as well upon the vasomotor center to produce its hypotensive effect. Like other central nervous system depressants, however, reserpine itself often reduces blood pressure only indifferently and is commonly used as auxiliary treatment.[1]

An important drug which acts upon vasomotor reflexes is veratrum. This consists of a large number of alkaloids isolated from Veratrum viride and other related species. Ten to 15 years ago purified products became available and produced a resurgence of interest in these drugs, the pharmacologic action of which is not completely understood.[2] Chiefly, it seems to involve the stimulation of a vasodepressor reflex.[3]

Veratrum alkaloids produce moderate lowering of systolic and diastolic blood pressure and lowering of pulse rate without changing cardiac output or significantly lowering renal blood flow. The main obstacle to the successful oral use of these agents is the small margin between the lowering of blood pressure and the occurrence of numerous toxic side effects, chiefly gastrointestinal.[4]

DRUGS ACTING PERIPHERALLY

The nitrites are examples of drugs which act directly upon the blood vessels. These drugs dilate large and small vessels and the postarteriolar vascular bed. They lower systolic more than diastolic pressures so that a fall in pulse pressure may be very prominent. Though the long-acting members of this group have often been incorporated in proprietary mixtures for the control of hypertension, there is little evidence that tolerated doses can maintain a hypotensive effect.

The introduction of dibenzyline® made possible clinical testing of sympatholytic and adrenolytic agents in man.[5] This and related drugs can produce adrenergic blockade, but at the expense of numerous side effects such as postural hypotension and reflex tachycardia. Hydralazine is in part an adrenergic blocking agent but central vasomotor effects are part of its hypotensive action. Serious toxic effects have limited its usefulness.

Ganglionic blocking in man became possible with the marked specificity of action of the tetraethylammonium ion (TEA).[6] Absorption of this drug from the gastrointestinal tract is so limited, however, as to make oral dosage impractical. Hexamethonium salts and pentolinium tartrate are clinically effective ganglionic block-

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ing agents. They are more satisfactorily, though occasionally irregularly, absorbed from the intestine, and have received considerable enthusiasm in drug therapy of hypertension.[7,8]

This report deals with clinical observation on ecolid,®* (chlorisondamine chloride), a recently introduced compound with laboratory properties which made it desirable for clinical appraisal. In laboratory animals it has demonstrated better absorption, greater potency and longer duration of action than the other ganglionic blocking agents, and clinical investigators have reported encouraging results in the lowering of blood pressure.[9,10,11]

METHOD OF STUDY

Eleven cases have been studied of which nine are reported here, the two remaining having been placed on ecolid® therapy too recently to justify proper evaluation. The method of study of each patient in this group has been as follows: Patients were selected who met the following criteria: (1) a history of long standing hypertension with or without overt symptoms; (2) a diastolic pressure of 90 or above; (3) no symptoms of cerebrovascular or coronary artery disease and (4) a cooperative patient.

Patients were then admitted for evaluation of their hypertension. This consisted of a history and physical examination with the following diagnostic procedures: (a) complete blood count, urinalysis, and serology; (b) blood urea nitrogen, serum creatinine, phenolsulfonphthalein excretion, urea clearance test, and concentration–dilution study; (c) chest x-ray; (g) regitine® or benodaine® test and (h) blood pressure readings taken with a mercury sphygmomanometer every two hours in the supine, sitting, and standing positions.

After 48 hours' observation of the blood pressure, ecolid® therapy was started with a small initial dose, 25 mg. daily in morning. By the second or third day all patients were shifted to twice daily therapy and the dosage increased according to their response. Blood pressure readings were continued at two hour intervals. When the optimum dosage of ecolid® had been reached, the patient was discharged from the hospital on this dosage and followed weekly in the outpatient medical department by the same physician, each visit being at about the same time of day.

Laboratory studies to evaluate the efficacy of the drug and the possible toxic effects were carried out periodically. The dosage of ecolid® was regulated according to the patient's clinical symptoms and blood pressure readings. Daily dosage ranged from 75 to 200 mg. in two divided doses, with the exception of one case where the dosage reached 1,200 mg. daily in four divided doses. During the outpatient observation and, unknown to the observer and patient, there was a period of placebo therapy, following which ecolid® therapy was resumed.

*Generously supplied by the Ciba Pharmaceutical Co., Inc.

RESULTS

Three case records are presented showing effects of placebo therapy, favorable response to ecolid® therapy, and absolute refractoriness to ecolid® therapy in a case of malignant hypertension.

Case No. 1: A 63 year old white female was admitted on September 25, 1955, complaining of weakness, tinnitus, squeezing headache, abdominal pains, gas and constipation. The patient was a mild diabetic controlled on 20 units of NPH insulin. There was occasional ankle edema and exertional dyspnea.

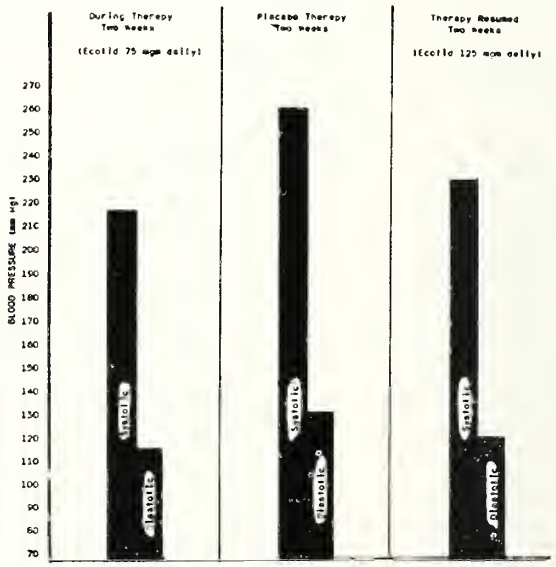
Physical examination revealed a blood pressure of 244/100, pulse rate 64, respirations 20. Eye grounds showed marked arterial narrowing bilaterally. The heart was enlarged to the left of the mid-clavicular line with a systolic murmur heard over the precordium. There were basilar rales bilaterally and Grade I pretibial pitting edema. The abdomen was negative. Renal function studies were normal. Chest x-ray showed cardiac enlargement and the electrocardiogram showed left ventricular hypertrophy and strain pattern.

Optimal ecolid® dosage was found to be 150 mg. daily with blood pressures ranging between 190/94 and 174/90. As an outpatient, blood pressures were slightly higher, averaging 217/115 in the supine and 178/106 in the standing position on a dosage of 100 mg. of ecolid® daily.

On January 9, 1956, placebo therapy was instituted and it was noted that the average blood pressure promptly rose to 260/130 in the supine and to 220/128 in the standing. At this time, the patient complained of slurred speech, drooping of the cheek and mouth on one side, dysphagia, headache, dizziness and tinnitus. It was felt she had suffered a mild stroke and she was hospitalized and re-started on ecolid® therapy. Figure 1 represents this patient's course during outpatient observation with the effect of placebo therapy.

Case No. 2: A 54 year old white male was admitted on October 16, 1955, in acute respiratory

FIG. 1. AVERAGE BLOOD PRESSURES WITH EFFECT OF PLACEBO THERAPY IN ONE PATIENT IN SUPINE POSITION.



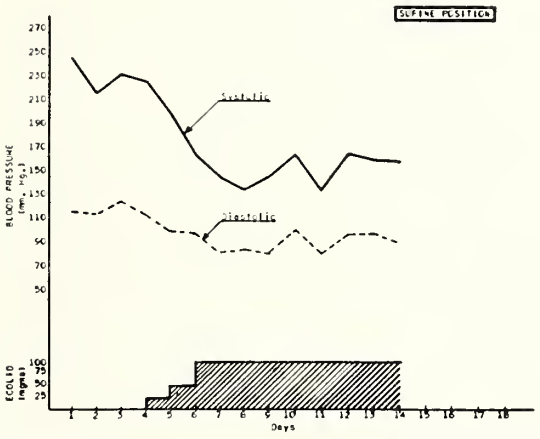
distress. He had been a known hypertensive for three years with symptoms of exertional dyspnea, paroxysmal nocturnal dyspnea, and episodes of vertigo one year prior to admission. About six hours prior to admission there was sudden onset of progressive shortness of breath.

Physical examination revealed a respiratory rate of 40, blood pressure 300/180, and pulse rate 150. There was bilateral dullness to percussion of the chest with diffuse inspiratory and expiratory rales. The heart was enlarged to percussion and there was a Grade II apical systolic murmur.

X-ray of the chest confirmed cardiac enlargement with pulmonary congestive changes. Electrocardiography showed a supraventricular tachycardia with atrial and ventricular extrasystoles. Tracings after treatment of the tachycardia showed left ventricular hypertrophy and strain. Renal function studies which on admission indicated moderate impaired function and nitrogen retention improved on hospital management.

Optimal ecolid® dosage was found to be 100 mg. daily in two divided doses. The patient's response to this therapy is shown by figure 2.

FIG. 2. AVERAGE DAILY BLOOD PRESSURES WITH EFFECT OF ECOLID® THERAPY.
(One patient)



Case No. 3: A 33 year old white male was admitted in July, 1955, complaining of progressive shortness of breath over the past few years with accentuation in the past two weeks. He was a known hypertensive since 1943 and during the year prior to admission complained of dyspnea, hemoptysis, anorexia, dizziness, blurring of vision, peripheral edema, paroxysmal nocturnal dyspnea and later polyuria.

Physical examination revealed acute respiratory distress, with generalized edema and severe apprehension. Blood pressure was 250/140. Pulse rate 108. Respirations 32 and temperature 100.2°. The optic fundi showed bilateral papilledema, cotton wool exudates, punctate and flame hemorrhages. There were scattered rales throughout both lungs.

The heart was enlarged to percussion with a Grade I systolic murmur. The liver was down three fingerbreadths below the costal margin and was tender. Kidney function studies were markedly abnormal, chest x-rays showed marked cardiac enlargement and pulmonary congestive changes and the electrocardiogram revealed left ventricular hypertrophy and strain.

Following treatment for congestive heart failure he was started on ecolid® therapy beginning with 75 mg. daily and gradually increased to 300 mg. daily upon discharge from hospital. During observation in the outpatient department the dosage was gradually increased to 1,200 mg. of ecolid® daily, with little or no effect upon his hypertension.

On January 5, 1956, he was readmitted in renal and congestive heart failure and death followed two months later.

FIG. 3. AVERAGE SYSTOLIC AND DIASTOLIC BLOOD PRESSURES IN THREE POSITIONS FOR A GROUP OF NINE PATIENTS UNDER ECOLID® THERAPY.
(Dosage range 75-200 mg. daily)

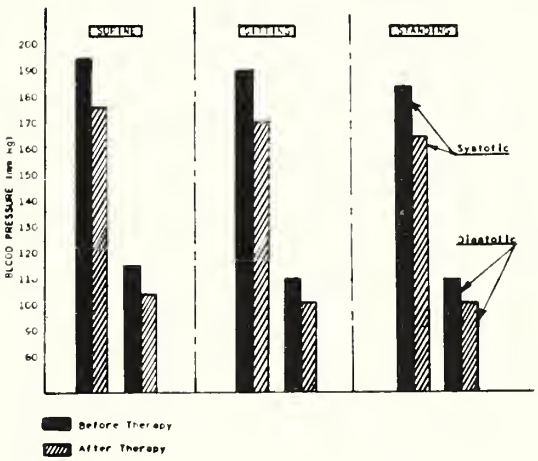


Figure 3 represents the average effect of ecolid® on the group of nine patients during hospital observation over an average period of two weeks. Considered individually, three patients had a satisfactory response; the response of the remaining six must be considered unsatisfactory.

All patients at one time or another showed side effects of the drug. These included blurring of vision, mouth dryness, and constipation.

DISCUSSION

In general, a good response to the management of hypertension with an anti-hypertensive drug is a 20 millimeter lowering of the diastolic pressure. This group showed an average lowering of 20 mm. of systolic and 10 mm. of diastolic pressures. This would indicate that ecolid® is of moderate value in the management of hypertension. The possible benefits of long-term ecolid® therapy remains to be evaluated.

Combination therapy of ecolid® and another drug, such as reserpine, may be more satisfactory than ecolid® alone. On ecolid® therapy alone there was satisfactory response in three out of nine patients. Our preliminary results seem to indicate that combination therapy might improve the percentage of satisfactory response. This will be the subject of a future communication.

The low percentage of satisfactory response is not due to failure of absorption, because these individuals all eventually manifest the side effects which occur when parasympathetic ganglia are blocked (failure of accommodation, dry mouth).

Apparently, then, in these patients, no vascular relaxation can occur from ganglionic blockade, either because some non-neurogenic factor is responsible for spasm, or because sufficient structural changes have occurred in their vessels that they can no longer dilate.

It should be noted that our small series did not include any examples of the young, labile, short-duration hypertensive that is known to be the best candidate for drug therapy.

The fall in blood pressure of the entire group was about the same in the supine, sitting, and standing positions. In those patients responding most satisfactorily to ecolid,® the response was most marked in the standing position. This is to be expected with a drug that acts by ganglionic blockage. *Case No. 2* illustrates this phenomenon, his blood pressure falling 84/33, 87/33, and 92/44 in the supine, sitting, and standing positions, respectively.

UNTOWARD EFFECTS

All of the side effects observed were those associated with ganglionic blockade. In no case in our series was the drug discontinued because of these effects. Pilocarpine 5 to 8 mg. given three or four times daily, satisfactorily controlled the side effects. No evidence of tissue toxicity from ecolid® was observed during the entire study. There was some evidence of the development of tolerance of the drug during the first few weeks of therapy, after which the response from each day's dose remained rather constant.

Case No. 1 illustrates the danger of sudden discontinuance of the drug, permitting a sudden rise in blood pressure and precipitating a cerebrovascular accident. There appears to be some divergence between the blood pressure lowering effect of the drug and the pharmacologic side effects of the drug. This is illustrated by several of the patients who showed side effects but no lowering of the blood pressure.

Case No. 3, which represents malignant hypertension, illustrates a failure in the management of this disease. It should be pointed out that huge doses of ecolid® produced no effect upon the disease process and there were no toxic effects observed. No parenteral therapy was attempted.

Several of the patients obtained sustained lowering of the blood pressure upon therapy while in the hospital, but exhibited a gradual rise in blood pressure during outpatient observation. This illustrates the difficulty in evaluating an anti-hypertensive agent in the hospital, under so-called ideal conditions.

SUMMARY AND CONCLUSIONS

Therapy with ecolid® was employed in nine patients with hypertension. Three patients responded satisfactorily.

Development of tolerance, but no tissue toxicity, was observed with this drug. Side effects typical of ganglionic blockade occurred in all patients, but did not prevent the continuance of therapy.

Sudden withdrawal of the drug can be dangerous, therefore caution in this regard is emphasized.

Further study with combination therapy is under way.

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Treatment of Vitreous Floaters With Iodo-Niacin®

Over 90 per cent of the 89 patients with vitreous floaters who were treated with iodo-niacin® showed subjective improvement, and 50 per cent showed objective improvement. Large vitreous floaters appeared to diminish in size and some of the fine, dustlike opacities disappeared entirely. In several cases the vitreous floaters disappeared completely; in others, they were reduced in size ophthalmoscopically after treatment with iodo-niacin® for one to six months. Not one of the 34 controls treated with the placebo improved subjectively after three to six weeks of observation.

Unlike other iodine preparations, for example, iod-ethamin,® used previously by us, no case of severe iodism occurred. Minor ill effects were noted in the form of an occasional bad taste in the mouth or pruritis with an acne-like dermatitis. The dermatitis cleared when the drug dosage was reduced from three times a day to once a day.—Ira A. Abrahamson, Jr., M. D., and Ira A. Abrahamson, Sr., M. D., Cincinnati: *Am. J. Ophth.*, vol. 42, No. 5, November, 1956.

The patient who has emphysema complicating asthmatic bronchitis has a similar problem (as that of the patient with asthma), but the irreversible changes in the lungs in this condition will not be helped by cessation of smoking. However, such patients usually have a considerable degree of bronchitis, which is aggravated by smoking tobacco.—G. A. Peters, M. D., and L. E. Prickman, M. D.: *Minnesota Med.*, 40:116, 1957.

Clinical Evaluation of Hesper-C Therapy

A. P. R. JAMES, M.D.

THE combination of hesperidin with ascorbic acid has been used successfully for the treatment of vascular purpuras of various etiology.[1,2] Reports have also been published indicating that hesper-C* is valuable in the prevention of abortion and in the control of easy bruising[3,4] and bleeding.[1,5] In these conditions and in a number of others reported in the literature, the action of hesperidin and ascorbic acid is considered to be the prevention of rupture of the capillaries or the reduction of excess permeability of the capillaries and venules. The two compounds together appear to be effective while either one alone is not. Rinehart and Johnson have concluded that the two act in conjunction to maintain a normal state of permeability in the capillary wall.

The importance of the state of the capillaries in dermatology has been discussed, but research has been sporadic and not very encouraging. Goldman and Corrill[6] found the incidence of capillary fragility to be high in patients with skin diseases, but they felt it was of no great practical significance nor could it be readily corrected with hesperidin.

In eczema, a Spanish group has reported that the capillary resistance can be increased with vitamin P (hesperidin) treatment, which is particularly effective in the acute and very exudative phases. They report disappearance of exudation and progressive diminution of erythema with abatement of subjective phenomena, particularly pruritus.

In the treatment of stasis dermatitis, available methods of increasing circulation in the involved area have not proven satisfactory. If the improved tone of the capillaries will permit more efficient interchange across the capillary walls, another method of improving metabolism in the involved area is available. On the basis of this hypothesis, an evaluation of hesper-C therapy was undertaken to observe the response of dermatologic conditions associated with vascular change. Most of the investigation was confined to the skin changes seen in legs with venous stasis.

In any investigation of the therapeutic value of a nonspecific procedure, so many factors must be evaluated that it is wise to have the results and opinions of more than one observer. Unfortunately, too many statistical reports have appeared in the literature which could never be confirmed by other investigators. In order to obviate a clouded story on one more regimen of treatment, it was decided before undertaking the study that negative results would be published immediately and that positive results would be confirmed as far as was possible before publication.

Submitted May 17, 1956.

*Hesper-C: Supplied through the courtesy of the Medical Research Department, The National Drug Company, Philadelphia 44, Pa.

The Author

● Dr. James, Toledo, is dermatologist to St. Vincent's, Mercy, Toledo, St. Luke's and Maumee Valley Hospitals; director, Department of Dermatology and Syphilology, City Clinics.

CLINICAL STUDY

Hesper-C was given to 61 ambulatory patients with stasis dermatitis. One capsule containing 100 mg. of hesperidin and 100 mg. of ascorbic acid was given four times daily for periods of three weeks to three months. Most of the patients were in their fifties. The youngest was aged 29 and the oldest 72.

In the series there were 24 females and 29 males treated in the office and eight males treated in my city clinic. The conditions varied from mild to severe with extensive ulcerations. In 18 of the cases the veins had either been ligated or injected and sympathectomy had been performed in four instances prior to the institution of hesper-C therapy. The following case report of a patient who was typical for the series was presented at a meeting of the Detroit Dermatological Society.

CASE REPORT

A 65 year old white man was seen in the office October 19, 1951, with a severe stasis dermatitis and generalized absorption "id" dermatitis. He stated that the condition started about six months prior to that date and had become progressively worse. He gave a history of lues in 1930, which was treated in the city clinic. Otherwise, his past history was not significant.

On examination there was generalized erythema. The patient complained of intense pruritus. The legs below the knee were edematous, fissured, and weeping. It was impossible for the patient to wear shoes. Serologic tests for syphilis were negative; urine normal; heart normal; pulse 90; blood pressure 140/80; chest and abdomen negative.

On the initial visit tocopherol E (100 mg. daily) was prescribed. Other treatment included colloidal baths, wet dressings and topical applications. Sustained action my-b-den®** was given intramuscularly and calcium gluconate intravenously twice weekly. Corticosteriod therapy was used for his generalized dermatitis and to control the pruritus.

In 1954, he was given injections of penicillin for several months and mysteclin®*** orally for

**My-b-den®—Bischoff, Ames Co., Elkhart, Ind.
***Mysteclin®—E. R. Squibb & Sons, New York, N. Y.

several weeks, because of the infection in his legs. His response was satisfactory.

In May 1955, the condition was so severe he was given a course of injections of parenzyme.®† During most of this time the patient received injections of B_{12},—1,000 units once each week, to help maintain his general health. Corticosteroid therapy had to be repeated on several occasions because of generalized flare-ups.

On June 13, 1955, the patient's legs showed erythema, with considerable edema and very slight improvement after almost four years of many types of therapy. On this date he was started on hesper-C therapy. He began to show slow improvement. One month later all other types of medication were discontinued.

Six months after instituting hesper-C therapy the patient showed slight residual dermatitis of the ankles. There was no swelling of any areas and the skin on the remainder of his body was perfectly normal. His general health was much improved and he stated that he felt fine. All medication was discontinued on February 1, 1956. When he was examined on March 19, 1956, his skin appeared normal.

RESULTS OF THERAPY

No untoward effects from therapy were observed. As would be expected, the mild cases gave the quickest and most satisfactory response. Where large ulcers were present they were given local therapy; all other patients in the series received no medication except hesper-C. In four cases it was felt that surgical procedures would be advisable.

As the investigation progressed, it was found that in cases with extensive ulceration hesper-C alone was not satisfactory. In these patients it was necessary to give intramuscular injections of trypsin. A report on this therapy is being prepared.

In no instance was the response to this therapy spectacular. In all probability some of the older patients persisted in taking their medicine because it improved their general health. The dermatological response for the entire series was roughly 70 per cent excellent, 15 per cent satisfactory, and 15 per cent slight. The improvement was maintained and the patients were satisfied.

During the time of this investigation hesper-C was given to groups of patients with other conditions. (See table 1.)

In cases of discoid exudative dermatitis hesper-C was given in addition to other routine therapeutic measures. In this condition the response occurred within a few days or not at all. In most instances exudation stopped within a week and the pruritus lessened. We were particularly impressed by the results in this condition since several of these cases had failed to respond to all other types of therapy. Our four cases of benign hemosiderosis showed considerable improvement, but none have cleared past a certain stage despite further therapy. The response in purpura was very satisfactory; however, it was necessary to repeat the hesper-C in most instances. Cases of psoriasis and cases of severe dermatitis venenata with extensive vesiculation showed no clinical response to hesper-C therapy.

†Parenzyme®—The National Drug Company, Philadelphia 44, Pennsylvania.

TABLE 1. HESPER-C THERAPY IN OTHER CONDITIONS

Condition	No. of Cases	Av. Duration of Therapy	Results
Discoid exudative dermatitis	23	3 weeks	Hesper-C was given as additional therapy 85% excellent improvement.
Benign Hemosiderosis	4	3 months	All cases showed limited improvement.
Purpura	6	4 weeks	All cases showed satisfactory response, but recurrence in 4 instances when hesper-C was stopped.
Psoriasis	20	4 weeks	No apparent value.
Dermatitis venenata	10	3 weeks	No apparent value.

COMMENT

Unfortunately the number of cases available was limited so that adequate control series could not be run. In evaluating the clinical response we considered the psychological effect of the ingestion of large colored capsules and the factor of response to suggestion. Our results in cases of stasis dermatitis would indicate that hesper-C is slow acting and certainly not spectacular, but the most satisfactory medicament we have used to date. It is also of some limited value in Schamberg's disease. Our cases of psoriasis and venenata showed no indication for its use in these conditions. Any medication which can produce favorable results even in a limited way on such trying conditions well warrants further investigation.

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Disordered Blood Coagulation

Up to now, clinical research in disordered blood coagulation has primarily been concerned with hemorrhagic diseases. This work has been rather rewarding. It has clarified several of these diseases, and contributed to a better understanding of the hemostatic mechanism. However, a clarification of the mechanism of *hyper*-coagulability and its significance for thromboembolic disease and especially of its relation to obliterative atherosclerosis, the great killer of man, must be the primary aim of future coagulation research.—Paul A. Owren, M. D., Oslo, Norway: *Northwest Med.*, 56:159, February, 1957.

Social Factors in Psychoneurosis

ROBERT M. FRUMKIN, M. A.*

PSYCHONEUROSIS is one of the most common mental illnesses which occurs among Americans. Of the first admissions to Ohio State mental hospitals in the year ended December 31, 1949, 3.7 per cent were psychoneurotics. Their median age was 40 years. Among the readmissions, 3.1 per cent had this mental illness. Of the resident population, 1.1 per cent were psychoneurotics. Their median age was 49 years. These patients spent a median time length on the hospital rolls of two years and 11 months. The ratio of female patients to male patients for first admissions, residents, and readmissions were respectively as follows: 1.3, 1.4, and 1.6 to one.

METHODOLOGY

The main objective of this study was to ascertain some of the social factors related to psychoneurosis. In order to obtain such facts all first admissions to Ohio State mental hospitals with psychoneurosis for the year ended December 31, 1949, were broken down statistically by sex, environmental background, education, race, marital status, and occupation. On the basis of the 1950 census of Ohio, rates per 100,000 specified population were computed for the social factors stated above.

FINDINGS

1. **Environment.** Urban rates were higher than rural rates of psychoneurosis. Thus, according to the 1950 census data, rates per 100,000 Ohio population were as follows:

Environment	Total	Male	Female
Urban	1.7	1.6	1.9
Rural	1.2	1.0	1.5

2. **Race.**—Whites had higher rates of psychoneurosis than did Negroes:

Race	Total	Male	Female
White	1.7	1.6	1.9
Negro	1.0	0.4	1.5

3. **Education.** There seems to be an inverse relationship between the extent of an individual's education and the probability of his being hospitalized as a psychoneurotic. Thus for persons 25 years of age and over, rates per 100,000 were as follows:

Education	Total	Male	Female
Elementary Schl.	3.1	3.7	2.4
High School	2.7	1.7	3.6
College	1.5	1.0	2.2

4. **Occupation.** There seems also to be an inverse relationship between rates of psychoneurosis and income, prestige, and socio-economic status as manifested in occupation. Thus, for 100,000 employed Ohio population differential rates can be found in table A:

TABLE A. RATES OF FIRST ADMISSIONS, BY SEX, BY OCCUPATIONAL GROUP, YEAR ENDED DECEMBER 31, 1949

Occupational Group	Total	Male	Female
Professional and Semi-professional	2.3	1.8	3.1
Managerial	3.2	3.2	3.1
Clerical, Sales	1.9	1.7	2.2
Skilled	3.2	3.1	6.5
Semi-skilled	1.6	2.0	0.0
Unskilled	7.0	6.8	13.5
Service	3.8	0.8	6.0
Agricultural	3.4	3.6	0.0

5. **Marital Status.** For persons 14 years of age and over, the rates by marital status, for psychoneurosis were as follows:

Marital Status	Total	Male	Female
Single	2.1	2.2	2.1
Married	2.0	1.7	2.4
Divorced or Widowed	2.7	2.9	2.5

DISCUSSION

It is evident from our findings that all factors indicative of social disorganization and low socio-economic status are associated with higher rates of psychoneurosis. This relationship was also found in the case of involutional psychosis.[1]

However, Negroes have lower rates than Whites in spite of the fact that they generally have low socio-economic status, less education, and more family disorganization. Why? One hypothesis might be that Negroes resolve their emotional conflicts by a type of defense mechanism which leads them to develop more severe mental illnesses. Thus the more extrovertive Negroes become alcoholic psychotics and syphilitic psychotics, the more introvertive ones become schizophrenics.[3] This hypothesis may thus explain, in part, why Negroes have higher rates of schizophrenia, alcoholic and syphilitic psychoses than do Whites. The validity of this hypothesis must be tested by a clinical study of the individual psychoneurotic.

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Submitted May 24, 1956.

The Treatment of Portal Hypertension

JOHN STORER, M. D.

PORTAL hypertension may result from any condition which compromises the free flow of blood through the portal system. Portal cirrhosis is patently the most common cause of this rise in portal venous pressure. In children, however, the so-called cavernomatous transformation of the portal veins is the usual etiologic factor. This report is concerned solely with the management of the cirrhotic patient with esophageal varices, one of the most fearful sequellae of portal cirrhosis.

The histologic pattern in portal cirrhosis is one of periportal fibrosis, biliary duct proliferation and hepatocellular degeneration. The intrahepatic capillaries of the portal vein are compressed by this combined proliferative productive tissue reaction. This process impedes drainage of the portal blood through its capillaries and is responsible for increasing the pressure in this circuit. The radicles of the portal vein originating in and draining the distal esophagus dilate, become engorged and enlarge in this situation. The action of the peptic acid factor in the gastric juice and a physiologic impairment of the cardiac sphincter are thought to be the precipitating factors in rupture of these esophageal varices.

Frequently the first awareness of esophageal varices by physicians and patient is on occasion of an alarming hematemesis. This situation may be catastrophic and requires vigorous treatment if the bleeding is to be controlled and death prevented.

SEQUELLAE OF HEMORRHAGE

A serious hemorrhage may represent sufficient trauma to precipitate hepatic coma. In this instance, one is presented with a critically ill individual and obviously the management must be vigorous if there is to be any salvage. In other cases, hepatic reserve may be surprisingly good and the patient will weather the crisis. In either case, control of the esophageal bleeding is the issue which demands attention. Several methods are available for the management of esophageal bleeding. These include esophagoscopic injection of sclerosing agents, transpleural ligation of the varices, transpleural gastro-esophageal resection and pneumatic tamponade.

The Blakemore-Sengstaken tube has been found to be effective in controlling such bleeding, (Fig. 1). After it has been inserted the stomach may be irrigated to be certain that bleeding has been controlled and that bleeding is not from a source lower in the gastrointestinal tract. This seems to be the least traumatic method which may be used to combat the hemorrhagic episode.

Submitted June 22, 1956.

The Author

● Dr. Storer, Cleveland, is director, Department of Thoracic and Cardiovascular Surgery, Huron Road Hospital.

Transpleural ligation of the varices requires a major operative procedure at a time when the patient can ill afford the burden of additional trauma. It has seemed wise, therefore, to follow a policy of nonoperative control of bleeding.

Blood replacement is carried out as soon as possible to avoid the hazard of shock and the ensuing deleterious effect of tissue hypoxia. If coma intervenes, careful attention to the airway is necessary. Tracheotomy is performed if there is any evidence of retained secretions. Other specific supportive measures are carried out which will not be considered since they are not within the scope of this review.

SURGICAL EVALUATION

When bleeding has been controlled and a state of well being re-established, the patient must be evaluated as a candidate for definitive surgical decompression of the portal tree. Most investigators agree that 50 to 80 per cent of bleeding cirrhotics untreated by definitive surgical decompression die of recurrence within a year after the initial hemorrhage. This may be contrasted to a survival rate of 70 to 80 per cent at the end of two years in the surgically treated patient.

It is the opinion of some that a history of hepatic coma interdicts the use of a shunting procedure. It is our opinion that this position is not justifiable since this group is least likely to withstand the trauma of the almost inevitable recurrent hemorrhage. True, the operative mortality will be high in such patients but it is overwhelmingly higher in the untreated patient.

The presence of jaundice, inability to maintain a serum albumin level of over 3.0 gr. per 100 cc. and presence of ascites are other criteria which many observers have used to contraindicate surgery. The problem of ascites in cirrhosis is one about which has sprung considerable controversy. It is generally believed that ascites is not a manifestation of portal hypertension. There is much clinical and experimental data to support this contention. At any rate, there has been no consistent mitigation in the formation of ascitic fluid in the cirrhotic following portacaval shunt. It can be controlled, however, fairly well by salt

restriction, dietary therapy and adjuvant measures aimed at increasing liver function.

Presented a patient with esophageal varices and ascites in whom fluid formation has been controlled by the foregoing measures, it is our feeling that he is a suitable candidate for a decompressive shunt. In the presence of jaundice and laboratory evidence of marked liver cell damage it is unwise to subject the patient to any surgical attempt at decompression.

CHOICE OF TECHNIQUES

When the patient has been considered a suitable candidate, one must make a choice between several available techniques. Hepatic artery ligation has been advocated as a method of reducing portal pressure but it has failed to fulfill its early promise. Likewise, splenectomy alone has not proven to be a feasible method.

Portacaval and spleno-renal shunt stand out as the most helpful procedures. Of these, portacaval anastomosis has proven to be the procedure associated with the highest index of clinical improvement and lowest rate of thrombosis. Spleno-renal shunt must be done in association with splenectomy. One of its great advantages lies in the fact that after a spleno-renal shunt, the liver is not completely deprived of portal blood as it is in the usual end to side portacaval anastomosis. Some investigators believe that liver function is diminished after the total portal blood flow is shunted around the liver. Direct evidence to support this conclusion is still lacking, however.

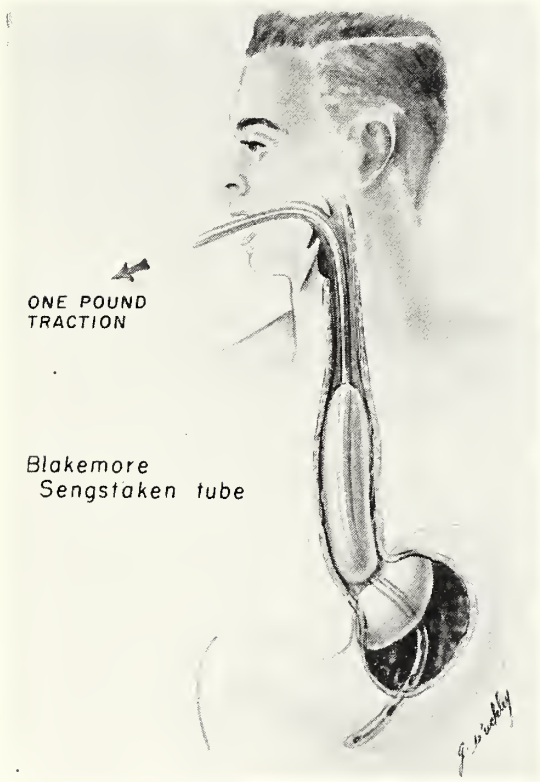


Fig. 1. Pneumatic tamponade of esophageal varices.

PREFERRED METHOD

It is the opinion of most observers that portacaval shunt is the preferred method when technically feasible. The patency of the portal vein may be ascertained by splenic portography. This technique consists of the percutaneous injection of the spleen with a radio-opaque dye. The dye when absorbed into the portal system clearly delineates the whole course of the portal vein, (Fig. 2). This procedure is accomplished under local anesthesia and has been done in a great many instances with no untoward reactions. If the portal vein is found, by this method, to be obstructed or obliterated a portacaval shunt is not possible. Spleno-renal shunt and splenectomy is the method of choice in this situation.



Fig. 2. Preoperative splenic portogram.

The technique of portacaval shunt is of some interest. A high right rectus incision is made and abdominal exploration carried out. The diagnosis of portal cirrhosis is confirmed by the appearance of the liver. Portal blood pressure may be measured by direct cannulation of one of the portal radicles. If the pressure is not elevated significantly above the normal 10 to 12 cm. of H_2O it is folly to procede with the shunt. If, however, the pressure is significantly elevated,

the incision is carried through the eighth intercostal space.

After incision of the diaphragm the triangular ligament is transacted and the liver rotated upward. The hepatic flexure is mobilized and retracted mesially and then dissection of the portal vein begun. It is often necessary to isolate the



Fig. 3. Postoperative splenic portogram—demonstrating patency of the portacaval anastomosis.

common bile duct and retract it from the underlying portal vein.

AVOIDANCE OF TENSION

Complete mobilization of the portal vein is the most important step in the entire procedure. The anastomosis must be made without tension. If there is tension, the vein becomes attenuated and the lumen diminishes in size. Tension is the prime factor in the development of thrombosis at the anastomatic site. Careful dissection of the portal vein in that portion lying under the head of the pancreas will often allow the necessary length for a tension free anastomosis. The vein is transected between angulated coarctation clamps and the distal portion closed with a continuous 5-0 silk suture. A Satinsky clamp is applied to the medial aspect of the anterior wall of the vena cava.

It is important to make the anastomosis slightly on the medial aspect as there will be less tension and a decreased tendency for the portal vein to become "thinned out."

Slight lateral rotation of the vena cava is made with the Satinsky clamp in place. A small elliptical section of the vena cava is made corresponding to the diameter of the portal vein. The transected end of the portal vein and the incised portion of the vena cava are irrigated with a solution of saline containing 30 mg. heparin in 200 cc. of saline. The anastomosis is effected with 5-0 silk. A simple continuous suture may be used or the operator may choose to use a posterior eventing suture and an over and over anterior suture line.

When the anastomosis has been completed, portal pressure may be checked. This should demonstrate a marked fall in portal pressure.

Simple closure of the wound is carried out after a thoracotomy tube has been inserted and a drain placed down to the gastrohepatic ligament. Postoperative care is like that for any major surgical procedure. The thoracotomy tube is removed when there is no longer drainage from the right hemithorax and the lung is completely expanded, usually the second postoperative day. Semi-Fowler's position is recommended by some to effect relaxation on the suture line.

A broad spectrum antibiotic is routinely used. It is to be emphasized at this point, however, that the operative procedure has done nothing to improve the liver function. Vigorous medical therapy is necessary to improve the hepatic reserve.

A few days prior to discharge, splenic portography may be repeated. This will demonstrate the patency of the anastomosis, (Fig. 3).

CONCLUSIONS

Portacaval and spleno-renal shunts are sound operative procedures. They are capable of relieving portal hypertension but they should not be given a bad name by expecting more than they are designed to yield.

Toxicity of Ozone

The toxicity of ozone is markedly decreased for mice if the ozone is administered in 100 per cent oxygen. However, 100 per cent oxygen does not affect ozone toxicity for rats and guinea pigs. This decrease in toxicity for ozone in 100 per cent oxygen for mice is indeed puzzling, since recent work indicates that 100 per cent oxygen administered after exposure to ozone in air does not protect mice from death by ozone poisoning.

Ozone poisoning is similar in some respects to oxygen poisoning in that both are pulmonary irritants. However, exposure to only 0.001 per cent of ozone for several hours can be fatal, while 100 per cent oxygen can be tolerated for as long as 24 hours before any effects are noted. Derangement of central nervous functions occurs when the oxygen is administered under pressure. There is no information available on the effects of ozone administered under pressure.—S. Mittler, D. Hedrick, and L. Phillips, Chicago: *Industrial Med. & Surg.*, 26:63, February, 1957.



A CONTINUOUS state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and assisted by official representatives of the various County Medical Societies of the state.

Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, will be published in *The Ohio State Medical Journal* from time to time. Each presentation will be brief but informative. It will contain opinions of the Committee, based on the data submitted for review. In the series of cases, entitled "Other Causes," the three cases in this eighth report have to do with maternal death due to amniotic fluid embolism.

CASE NO. 120

The patient was a 40 year old, white, gravida II, Para I, at term, who died undelivered, near term. The past medical history was unavailable, except the first pregnancy was at 32 years of age, uneventful antepartum course, normal delivery at term of live infant, and a normal postpartum convalescence.

During this second pregnancy no comprehensive antenatal report was available, however, the prenatal course was said to have been normal; the total weight gain was 6 pounds. No specific mention was made of blood pressure, urine analysis or edema or serologic test for syphilis. The number of prenatal visits was not obtained, either.

At term the physican was notified that the patient had a small amount of vaginal bleeding with no labor. The patient was hospitalized and a sterile vaginal examination was carried out in the delivery room. Diagnosis was made of vertex presentation, with partial separation of the placenta. The membranes were artificially ruptured 1:35 p.m. Labor ensued and in a short time the contractions were tumultuous. Analgesia given at 3:25 p.m. consisted of demerol® 100 mg.; scopolamine gr. 1/200, intramuscularly. The patient passed into a state described as "respiratory collapse." At 4:30 p.m. a transfusion was started. No response was evident and the patient died undelivered. An autopsy permit was obtained.

Pathological Diagnosis: Massive pulmonary amniotic fluid embolism, result of partial separation of placenta.

COMMENT

The Committee voted this case a nonpreventable death. It is an acceptable procedure, when indicated, to carry out amniotomy in a case of partial separation of the placenta. It was noted that no intravenous pitocin® was used in this case; the hard, severe, labor contractions were established after the amniotomy.

The same story with appropriate findings has been repetitious since 1941 when first described—bleeding, ruptured membranes, tumultuous labor, sudden shock, death. The final diagnosis in this case was proven only upon postmortem examination. Thus the importance of securing an autopsy is reiterated, especially in all cases which meet sudden death.

CASE NO. 132

This patient was a 32 year old negro, gravida V, Para IV at term, who died undelivered. The past medical history was not contributory; obstetrical history—four previous normal pregnancies, deliveries and postpartum convalescence. All live births.

During the last pregnancy the patient made a total of 10 prenatal visits, the last visit made at 35 weeks gestation. No complications were noted on her record, the blood pressure and urine were normal. No evidence of edema, the amount of weight gain was not noted. At 35 weeks gestation the blood pressure was 124/80 and this was the highest recorded in the 10 visits. The patient was said to have had no headache or bleeding during the pregnancy; serologic test for syphilis was negative.

At 38 weeks gestation, the patient was said to have had a convulsive seizure at home. She was immediately sent to the emergency room of the hospital where she was pronounced dead upon arrival. Autopsy was carried out.

Pathological Diagnosis: (1) Amniotic fluid embolism to lungs; (2) Interstitial pneumonia; (3) Pulmonary edema; (4) Parenchymatous degeneration of liver; (5) Abscess, left kidney;

(6) Acute glomerulonephritis; (7) Eclampsia; (8) Cerebral edema; (9) Pregnancy, uterine, near term.

COMMENT

The Committee voted the death nonpreventable. Again the postmortem examination revealed the diagnosis! The liver and brain displayed pathologic change characteristic of eclampsia. It was interesting to the Committee that at least two other cases similar to this had been reported in the literature, however, the convulsions were not confirmed by characteristic pathologic change in the liver and brain as in eclampsia. This patient was seen by the physician at 35 weeks gestation and three weeks passed without observation. Two or three of the most important prenatal visits—at 36 weeks, at 37 weeks and at 38 weeks—were missed. It was considered doubtful that the eclampsia was directly related to the amniotic fluid products found in the lungs.

Convulsive toxemias have been associated with afibrinogenemia (not present in this case) but this has not been described as due to infusion of ammniotic fluid into the maternal circulation. A different mechanism is said to give rise to the coagulation defect in eclampsia.

CASE NO. 97

This patient was a 38 year old, white, gravida IX, Para VIII, who died 54 minutes postpartum. Past medical history was negative except for acute infectious hepatitis in 1952. Following her previous pregnancies she had experienced difficulty with varicose veins of the lower extremities. General physical examination when first seen during the last pregnancy was normal, serologic test for syphilis negative, blood type O Rh positive. Four prenatal visits were made to her physician.

Labor ensued at term and she was admitted to the hospital at 6:30 a. m. in early labor, the progress slow. At 2:40 p. m. a dark clot was passed and a transient cyanosis was present. The patient was examined by her physician and neither the clot nor the cyanosis could be accounted for.

At 3:00 p. m. a sterile vaginal examination was carried out, an amniotomy was done. The fluid was noted to be meconium stained. Active progressive labor followed. Medication given—demerol® 50 mg. and scopolamine gr. 1/150 intramuscularly and at 3:30 p. m. complete dilatation attained, ether inhalations were started by graduate nurse. At 3:46 p. m. a living male infant (weight 7 pounds 5 ounces) was delivered as right occiput anterior low forceps over a midline episiotomy. Placenta and membranes delivered intact at 3.50 p. m. and patient was given 1 cc. pituitrin® intramuscularly. A small cervical laceration with minimal bleeding was noted and repaired as well as the episiotomy.

Upon reacting from the anesthesia, the patient complained of chest pain and experienced difficulty in breathing. At this same time marked vaginal bleeding was present. At 4:05 p. m. patient was very cyanotic. At 4:26 p. m. blood pressure 66/20, oxygen was started as well as 500 cc. whole blood. Dextran 250 cc. and one gram of fibrinogen were given. At 4:30 p. m. fundus soft, and at 5:00 p. m. the uterine cavity was packed; 1 cc. desoxyn® was given intravenously and intramuscularly. The blood pressure was not obtainable, pulse very weak and rapid, respirations shallow. At 5:10 p. m. 10 cc. adrenal cortex was given without change in condition. At 5:20 p. m. 2 cc. coramine® was given intravenously. In spite of all medication respirations ceased at 5:40 p. m. Autopsy permission was obtained.

Pathological Diagnosis: Amniotic fluid and meconium emboli to lungs; laceration of cervix, puerperal.

COMMENT

The Committee voted this case nonpreventable. Again the diagnosis was made at postmortem examination. The Committee felt the cause of the postpartum hemorrhage was possibly due to a coagulation defect, not confirmed however since no examinations were made upon the blood. Afibrinogenemia is quite frequently associated with amniotic fluid emboli if the patient survives the initial shock (Reid, Weiner & Roby*). One cannot be certain that this patient would have survived if the fibrinogen level in the blood had been stabilized within normal limits.

COMMENT OF CONSULTANT

The following comment of a consultant who is a specialist in pathology, was given at the request of the Committee.

For some unaccountable and probably perverse reason, man became interested in the experimental effects of intravenously administered amniotic fluid in 1927, but it was not until 1941 that the accidental infusion of amniotic fluid was suspected as a possible cause of certain obstetrical deaths. To this day the precise nature of this tragic accident has not been elucidated nor the mechanism agreed upon.

Clinically the victim is usually an older multipara whose pregnancy has been uneventful. Often the patient is overdue and the fetus is usually larger than normal. Labor is violent or tumultuous with hard, sometimes tetanoid contractions. There may or may not be evidence of premature placental separation.

The first symptoms occur during labor or shortly after delivery and consist of chilliness, restlessness, and anxiety followed by dyspnea, cyanosis, shock, collapse and death in a matter of minutes. Should the patient rally from the initial shock phase, hemorrhagic tendencies may develop quite rapidly and the blood may become incoagulable. The fetus may be stillborn or die shortly after birth.

The diagnosis of amniotic fluid embolization is proved only at autopsy by demonstrating elements characteristic of amniotic fluid or meconium (squame, mucous, lanugo hair) in blood from the right heart or in sections of pulmonary arterioles

*Reid, E. Duncan; Weiner, Albert E., and Roby, Charles C.: Afibrinogenemia and Amniotic Fluid Embolism. Am. J. Obst. & Gynec., 66:465-474, September, 1953.

and capillaries. Other findings are only those due to anoxia.

It is logical and has been observed that the membranes have ruptured, that the pelvic outlet is blocked and that amniotic fluid infusion is produced by violent contractions associated with abnormally opened uterine or placental vessels as in placenta accreta, cesarian section, rupture of the uterus, partial retention of the placenta and premature marginal separation. From this brief account of the pathogenesis, it is understandable that all degrees of the process may occur from undiagnosed sublethal doses to extensive infusions. When death occurs it is possibly due to anaphylactoid shock, widespread intravascular clotting or possibly plugging of small pulmonary vessels by particulate material.

Anaphylactoid phenomena have been known for years and since 1886 it has been known that tissue extracts were capable of producing coagulation defects. The latter occurs by virtue of their thromboplastin content. Amniotic fluid, placental extracts and especially decidual tissues are rich in thromboplastin. Intravenously administered, thromboplastin, placental extracts and unfiltered amniotic fluid will produce an initial shock-like phase in experimental animals. Widespread intravascular fibrin clots are said to form shortly, depleting the body store of fibrinogen. If severly depleted, the blood loses its ability to coagulate.

The wisdom of the Committee in classifying these three cases as nonpreventable is to be commended. Amniotic fluid embolization is an accidental, sudden devastating and many times dumbfounding catastrophe. Fortunately it is rare and unlikely that a high percentage of maternal deaths may be attributed to it. To March 1956 there have been reported 56 proved cases in the British and American literature. The incidence given by various authors varies from 1 in 8,000 deliveries to 0.37 per 10,000 live births. In some quarters, the clinical diagnosis may be made more frequently than the accident actually occurs when death is due to more commonly occurring undiagnosed catastrophes such as ruptured uterus, abruptio et cetera.

It is discouraging to conjure methods of preventing amniotic fluid embolization and difficult to imagine a set of circumstances in which the emergency could be successfully met. In the initial shock phase, if anaphylaxis is the mechanism, antihistamines plus other supportive measures are certainly indicated. Small doses of heparin might prevent intravascular clotting. In the secondary phase fibrinogenopenia may be diagnosed by personal observation of clot formation or lack thereof. If available, fibrinogen up to complete replacement (6 to 8 grams) might be tried.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met at the Columbus Health Center on January 16, 1957. Three cases were presented.

Case No. 41: A 50 year old female Para VI, Abortus I. One year prior to admittance she had intermenstrual bleeding. First medical consultation: ten months later when she came into clinic following episode of heavy vaginal bleeding and clotting. A dilatation and curettage and cervical biopsy were advised. However, patient left town. Three months later she returned and was admitted to hospital.

Pelvic examination revealed a large, hard, nodular cervix with fibroids extending half way to the umbilicus. There was extension to right pelvic wall and half way to the left. A dilatation and curettage and cervical biopsy were done. Pathology: Poorly differentiated squamous cell carcinoma. 3,500 R. central cobalt was given.

Comments: DR. ANTHONY RUPPERSBERG: Why was there no report of a papanicolaou smear at the time of first clinical visit?

DR. FRANK DONLEY: Ten months patient delay. Three months physician delay.

Case No. 42: A 36 year old female, Para VIII, whose last normal delivery terminated eight weeks prior to admittance after history of vaginal bleeding at five months' gestation. The patient first saw a physician when she was in her 36th week of pregnancy. A diagnosis was made of carcinoma of the cervix when patient was in labor. On admission, examination revealed complete replacement of cervix by tumor tissue. Right fornix obliterated with involvement of vagina and right fornix. Extension to right pelvic wall.

It was decided that external therapy should be first since patient was only two months postpartum. She received external therapy and was admitted one month later at which time a biopsy of bilateral lymph nodes was made and insertion of cobalt was done. She received 3,500 R. to point A. Pathological diagnosis: Moderately well differentiated squamous cell carcinoma of the cervix. Lymph nodes revealed no carcinoma. She is completing external therapy.

Comments: DR. JONATHAN BUSBY: In the case of vaginal bleeding during pregnancy, an examination should still be done.

DR. FRANK DONLEY: Patient delay eight months; physician delay, five weeks.

Case No. 43: A 57 year old white female was admitted with symptoms of spotting and irregular vaginal bleeding for past seven years. Dilatation and curettage 10 months prior to admittance. Pathological diagnosis was cystic hyperplasia of endometrium. Three months prior to admittance, she had bleeding. Pelvic examination on admission revealed uterus enlarged; ovaries normal. With pathological diagnosis of cystic hyperplasia 10 months prior to admittance and the fact the patient continued vaginal bleeding, she was admitted for a hysterectomy. Pathological diagnosis: moderately well differentiated adenocarcinoma of the endometrium.

DR. BUSBY: Patient delay three months; physician delay, none.

The Present Status of Bed Rest In Pulmonary Tuberculosis*

WILLIAM J. HABEEB, M.D.

OVER the years, the policy regarding bed rest in the treatment of tuberculosis has not been uniform in all hospitals. The policy has varied in this country and abroad. Also, it has varied as to time and place. For example, during the time that Dr. James Amberson, in New York City, was vigorously expounding the principle of strict bed rest, in other sections of the country a liberal modified bed rest program was being followed. The proponents of each policy claimed equally good results. On the surface they differed, but were not so divergent as one may think. The policies varied only in the degree of bed rest used, but the common denominator of both was bed rest.

In recent years, numerous advances have been made in the treatment of tuberculosis. The introduction of drugs and new surgical techniques which are now widely used has led many physicians to doubt the need of bed rest. The status of bed rest in the treatment of tuberculosis has changed somewhat but the principle of rest therapy has not been abandoned.

REST AND DRUGS

Reports of the effectiveness of antimicrobial therapy in the ambulatory treatment programs in several large cities have given rise to the impression that drug therapy is a cure-all in the treatment of this disease, and that such therapy is a substitute for bed rest. Much home and office treatment rather than hospitalization is based on this false premise. It should be made clear that these so-called ambulatory programs were instituted primarily because of the shortage of hospital beds. Furthermore, the ambulatory drug therapy program was only part of an overall program which included a provision for bed rest in the home until hospitalization could be effected. The truth is, that drugs are not a substitute for bed rest. Bed rest still has a fundamental place in the treatment of tuberculosis.

Without question antimicrobial therapy has helped to lower the case mortality rate in tuberculosis and has shortened the time of recovery in the average case. However, the proper management of every patient still requires the intelligent utilization of bed rest, drugs, and surgery when it is indicated.

*This is one of a series of articles on chest diseases sponsored by the Ohio Trudeau Society, medical section of the Ohio Tuberculosis and Health Association.

Submitted December 3, 1956.

The Author

● Dr. Habeeb, Springfield, is Superintendent and Medical Director of Clark County Tuberculosis Sanatorium.

HOW MUCH REST?

No universal definitions need be given for strict and modified rest. Generally speaking, strict bed rest means 24 hours a day in bed, mostly in the reclining position, except for sitting up in bed for meals, periods for reading and writing, or other simple activities. Modified bed rest means about 20 hours a day reclining in bed, eating meals in nearby dining rooms, bathroom privileges, light occupational therapy, and so on.

Most physicians are familiar with the strict bed rest program imposed on patients in the past, regardless of the stage of the disease or the presence or absence of local and constitutional signs and symptoms. Today, most phthisiologists steer a more rational but still conservative course in the use of bed rest by individualizing the rest and activity programs of each patient, depending on the clinical, x-ray and laboratory findings in the particular case. Under proper management, utilizing all the new tools in our armamentarium, we certainly do ambulate our patients earlier, initiate rehabilitation earlier and return them to functional usefulness more rapidly than ever before.

In general, most patients should receive a period of relatively complete bed rest, with drug therapy, until constitutional symptoms have disappeared, x-ray changes have stabilized for the most part, and cavities have decreased in size or persist unchanged. A period of rest after surgical therapy is also indicated. Not even modified bed rest should be terminated until sputum has been negative for tubercle bacilli by culture. At this point, physical rehabilitation may be carefully graduated over a period of time determined by the status of the patient, with the aim of returning him to a safe and useful life.

Plasma Prothrombin, Serum Prothrombin and Thromboplastin Generation Tests

Aids in Study of Defects in Coagulation—(No. 1)*

DISEASE states characterized by bleeding tendencies are often due to abnormalities in the coagulation of blood. Coagulation occurs in three phases. In phase one, thromboplastin is generated. At least five factors are needed for this generation including platelets, antihemophilic globulin (AHG)), plasma thromboplastin component (PTC, Christmas factor), calcium, and probably plasma thromboplastin antecedent (PTA). A deficiency of any one will result in inadequate generation at a reduced rate. The latent period observed between venisection and visible coagulation, (clotting time) represents the period in which thromboplastin is generated.

In the second phase of coagulation, plasma prothrombin is converted to thrombin by calcium and the previously formed thromboplastin. Accelerator factors, labile factor (ACG, factor V) and stable factor (VII, SPCA or convertin) are necessary to speed this reaction and hence determine the final yield of thrombin from prothrombin. This reaction in contrast to phase one occurs in a matter of seconds rather than minutes.

The third phase of the reaction, the conversion of fibrinogen to fibrin (through the action of thrombin) and the formation of a solid clot likewise occurs very rapidly. A deficiency of calcium even in extreme degree plays no clinical role in defective clotting, even though it is necessary for clot formation, since this ion is always present in excess as regards this need.

In the Quick one stage assay of plasma prothrombin, the first phase of coagulation, the generation of thromboplastin, is by-passed by the addition of preformed thromboplastin derived either from rabbit brain or beef lung preparations. This substance plus calcium are both added in excess to the plasma under study. The rate of the reaction in seconds is the plasma prothrombin time.

Since prothrombin concentration is curvilinear, a few seconds in clotting time represents a considerable difference in the concentration of prothrombin and may, therefore, be reported in "seconds" or as per cent of normal concentration. It is now known that not only a deficiency of prothrombin itself will alter the rate of this reaction but the rate will also be altered by a deficiency of either of the accelerator factors (labile or stable factor); by heparin in excess, or by fibrinogen of low content, (less than 100 mg./ml. of plasma).

Dicumarol® depresses the production of both prothrombin and stable factor. These factors and the labile factor may be depressed in liver disease. If we know the limitations of the plasma prothrombin test and the disorders in which prothrombin and the accelerator factors may be altered, the method provides a most valuable clinical tool. The "normal" or 100 per cent value should be determined in each laboratory against controls and is dependent on a number of factors including the type of thromboplastin used.

After blood clots an appreciable amount of prothrombin *remains* in the serum. When blood is allowed to clot under standard conditions of temperature for a fixed interval of time, the amount of prothrombin remaining in the serum becomes an excellent index of the adequacy of the production and utilization of thromboplastin. This can be determined by adding to the serum a source of fibrinogen, calcium and thromboplastin and again doing a prothrombin time determination. The more prothrombin remaining in the serum the shorter the clotting time of the serum will be. This will indicate that in the original clotting the generation and utilization of thromboplastin was poor.

A long serum prothrombin time determined after a standard interval indicates that most of the prothrombin had already been converted to thrombin and it would further indicate efficient generation and utilization of thromboplastin. The "normal" serum prothrombin time is over 25 seconds.

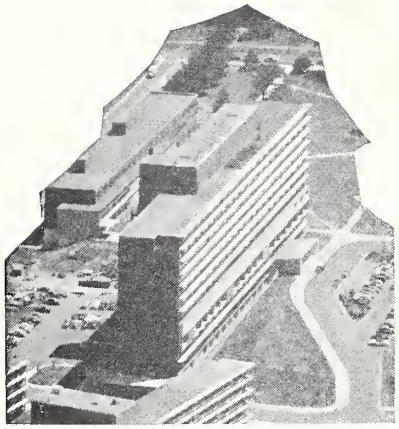
A true deficiency of any one of the five factors used to generate thromboplastin will result in a short serum prothrombin time. Relatively simple studies will clarify about 80 per cent of coagulation disorders. For more detailed tests see MacFarlane and Biggs (*Human Blood Coagulation*, C. C. Thomas, 1953).

The Author

● Prepared for the information of all Ohio physicians by the Ohio Society of Pathologists.

*Those desiring reprints of this article may secure them by writing to the Ohio Society of Pathologists, 267 E. Broad Street, Columbus 15, Ohio.

Submitted February 1, 1957.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Ralph J. Johansmann, M. D., President

Presented by Robert N. Watman, M. D., and Emmerich von Haam, M. D. Edited by Dr. von Haam

PRESENTATION OF CASE

THIS 58 year old white man was admitted to the hospital because of jaundice of seven weeks' duration and nausea with vomiting of three to four days' duration. Seven years ago he had had a cholecystectomy and numerous gallstones were removed at the operation. The patient was not jaundiced at this time. He had felt well since then except for "nervousness" which was responsible for his dropping the grocery business two years later. Three months before his present admission he began to feel "draggy" and one month later he noted dark urine and light-colored stools. These symptoms were followed by jaundice one week later, and the patient had remained at home in bed since that time. During this time his appetite had been poor and there had been marked weight loss.

During the past four days the patient had been severely nauseated and vomited about one and a half hours after nearly every intake of liquid or dry food. He also complained of fullness in the right upper quadrant of his abdomen and of soreness in that area on deep breathing. His last bowel movement occurred the day prior to admission, and the stools had remained light-colored for the most part of his illness. He did not complain of abdominal cramps, epigastric pain or back pain.

The past history revealed good general health except for high blood pressure and nervousness. A review of his systems revealed some complaints of tinnitus for an unknown number of years. No urinary symptoms were reported. There was no family history of tuberculosis, cancer or diabetes. One brother was suffering from an ulcer. The patient did not consume alcoholic beverages.

Submitted January 24, 1957.

PHYSICAL EXAMINATION

The patient was a thin, chronically ill white man who was markedly jaundiced. His blood pressure was 170 over 70, the pulse 80, his respirations 20 and his temperature 98° F. His weight was not given. The skin showed severe icterus with numerous scratch marks over the abdomen. The sclerae were icteric; the pupils were round and regular; there was Grade I arteriosclerosis of the fundi. The ear drums were icteric. His teeth were in poor condition and he had a dry, black coated tongue. The thyroid was palpable but not enlarged. The lungs were resonant and clear to auscultation. The heart had a normal rhythm with no murmurs.

A cholecystectomy scar was present in the right upper quadrant. The liver edge was felt 2 to 3 cm. below the right costal margin on deep inspiration, and some fullness and muscle resistance were noted in the right paramedian area, but no mass could be definitely outlined. The spleen was not palpable. The abdomen seemed generally soft. No bowel sounds were heard. There was no costovertebral angle tenderness, and the liver was not painful on deep palpation. Rectal examination showed "light-colored stool" and a moderately enlarged and boggy prostate. The anal sphincter was tight. Examination of the extremities and of his nervous reflexes was not remarkable.

LABORATORY DATA

Examination of his urine showed deeply amber-colored, cloudy urine with a specific gravity of 1.013, containing 20 mg. of protein, no sugar or acetone and giving a 3 plus reaction for bile; the microscopic examination revealed 10 to 15 white blood cells, 5 to to 7 red blood cells and a few finely granular casts per high powered field,

some bacteria and much amorphous material. A 24 hour determination of urine urobilinogen gave 6.4 mg. His red blood count was 2.69 million, his hemoglobin 6.4 Gm.; the white blood cells numbered 27,800 with 87 per cent neutrophils and a moderate shift to the left. The red blood cells showed hypochromia and anisocytosis. His hematocrit was only 20 per cent, the sedimentation rate was 74, corrected 16.

His admission blood urea nitrogen was 109.5 mg. and three days later was 159.5 mg. His fasting blood sugar was 169 mg., the carbon dioxide combining power 40 vol., and his serum amylase 111 units. The cephalin flocculation and thymol turbidity tests were negative. His blood chemistry also showed a serum phosphorus of 78.6 mg., an alkaline phosphatase of 34.6 units, no acid phosphatase, a total protein of 5.2 mg. with 3 mg. of albumin and 2.2 of globulin. The van den Bergh reaction was 34.4 mg. indirect and 24.4 direct. The prothrombin time was less than 1 per cent of the normal, the plasma sodium was 135 mEq., the potassium 4.5 mEq. His serologic test for syphilis was negative.

ROENTGENOGRAPHIC STUDIES

The flat plate of his abdomen showed a moderate amount of gas in the colon and some distention of the small bowel. The liver and splenic shadows were smaller than expected. Osteoarthriti proliferations about the vertebral margins and muscle attachments to the pelvis and femur were noted. The bones were of good density. The outline of the stomach on roentgenogram appeared within normal limits with the barium probably diluted by blood clot.

HOSPITAL COURSE

A low-fat diet was instituted. On the first day he received 1,000 cc. of 5 per cent glucose in saline and 500 cc. of glucose in water. On the second and third days he was given 1,000 cc. of 5 per cent glucose in water each day. The urine output was recorded as 400 cc. on the first day, 800 cc. on the second day, and 450 cc. on the third day. In the early morning of the third day the patient complained to the nurse of severe abdominal pain and was given morphine. Later that morning he was taken from his room for x-ray pictures and as the upper gastrointestinal series was begun the patient vomited coffee-grounds material and fainted. He went into shock and became almost pulseless.

The patient was taken back to the floor, where oxygen by mask was started, 500 cc. of whole blood and 0.2 cc. of adrenalin given. An hour later the blood pressure was 94 over 50, pulse 100. Two hours later the blood pressure was 100 over 50, and three hours later it was 84 over 40 with no radial pulse palpable by the nurse. The patient remained in deep shock in spite of neosynephrine® and adrenalin. He was pronounced dead at 3:30 p. m. on the third hospital day.

CLINICAL DISCUSSION

DR. ROBERT N. WATMAN: As we go over his history and physical examination the first thing that strikes us is that we deal with a problem of jaundice, and before we go into any further details we must consider what type of jaundice this could be on the basis of the patient's history and physical examination. Let us consider first nonobstructive, or hepatocellular, jaundice. Now there are certain facts in his history that suggest that this is not a hepatocellular jaundice. For one thing he apparently suffered from an unremitting and steadily progressive jaundice.

The statement that it lasted seven weeks and that he was not very sick before his jaundice appeared tend to suggest that this was an obstructive and not a hepatocellular jaundice, and we must consider all the lesions which commonly cause obstructive jaundice. First, one would think of a malignant tumor, whether of the duodenum, the ampulla of Vater, the bile duct or the head of the pancreas. Second, one would consider a common duct stone, which is another very common cause of obstructive jaundice, and then there are some less common causes. For example, pancreatitis or a post-bulbar duodenal ulcer can occasionally do this, or one may consider an aneurysm of the hepatic artery, which is capable of causing obstruction and obstructive jaundice.

ANALYSIS OF DATA

Let us analyze the laboratory data to see what help they are in determining the type of jaundice we are dealing with. His plasma proteins are relatively normal although perhaps a little low, and so is his A:G ratio. This and the negative thymol turbidity and cephalin flocculation tend to suggest that his jaundice was not the result of primary liver damage. Another very strong argument for obstructive jaundice is the elevated alkaline phosphatase, which rises probably because of overproduction of the enzyme by the lining cells of the bile ducts. The results of the van den Bergh tests again are compatible with obstructive jaundice.

The prothrombin time of less than 1 per cent of normal suggests either that the liver was heavily damaged and thus incapable of producing prothrombin, or that the lack of bile in the intestinal tract prevented the absorption of vitamin K. Since the patient did not receive vitamin K while in the hospital, this test cannot be truly evaluated.

The only laboratory finding which speaks against obstructive jaundice is the normal urobilinogen excretion in the 24 hour urine sample. Since urobilin is formed normally only after the bile gets into the gastrointestinal tract, its excretion product, urobilinogen, should be low or absent in the urine in obstructive jaundice, and

we must find some explanation for it. Thus I may summarize that the history as well as most of the laboratory tests speak for a well documented case of obstructive jaundice.

How do we explain the nausea and vomiting that all of a sudden came after seven weeks of jaundice, and why should a patient vomit in this peculiar clocklike fashion an hour and a half after eating? This suggests some high obstruction of the gastrointestinal tract, and we are forced to consider a duodenal obstruction along with the biliary tract obstruction.

Which lesion can produce a biliary obstruction along with duodenal obstruction? A tumor certainly can do it. In fact, when we operate for a non-resectable tumor of the pancreas our idea of palliation is to transplant the bile duct and do a gastroenterostomy at the same time, because we know that tumors of the head of the pancreas do cause duodenal obstruction. A stone cannot do it, but pancreatitis can do it occasionally and so can a post-bulbar ulcer of the duodenum. So the most common lesion that would cause symptoms like these would be cancer, while a less common one would be a post-bulbar ulcer.

Could he develop an ulcer secondary to his jaundice? Yes, since the lack of bile in the duodenum would prevent the neutralization of the acid gastric contents. So we can say then that it is possible that he either has a tumor obstructing his bile duct and also possibly his duodenum, or that he has a lesion obstructing the bile duct and that consequently he is developing a duodenal ulcer which is making him vomit.

LEUKOCYTOSIS

Let us continue to study his laboratory data. His leukocytosis with a shift to the left is quite compatible with a carcinoma of the pancreas, the bile duct or the stomach. It is also compatible with an obstructive jaundice which has caused some infection of the bile ducts followed by cholangitis. In a case of cholangitis you also can observe conversion of bilirubin to urobilin within the infected bile ducts, which would explain his normal urobilinogen excretion. His slightly elevated fasting blood sugar would also be compatible with a carcinoma of the pancreas, which often causes some diabetic tendency in the patient.

His amylase determination does not have a great deal of significance. The measurement of serum levels of pancreatic enzymes as a diagnostic test for carcinoma of the pancreas has been up to now very unreliable with perhaps the exception of lipase determination. A single determination is of no help to us even in the diagnosis of pancreatitis.

How can we explain his rising blood urea nitrogen? I think that this can be explained in one or more of three ways. First, it could be the consequence of his jaundice. We know that severe jaundice can produce renal damage—the so-called cholemic nephrosis which characteristically can give you an elevation of the blood urea nitrogen, granular casts in the urinary sediment and diminution in the ability to concentrate. Second, we know that he is hypertensive and it may be that he has some degree of renal damage due to his nephrosclerosis. He may also have primary kidney disease such as glomerulonephritis, but I do not think that this assumption is necessary on the basis of the data we have before us.

Finally, a few comments about his severe anemia. Patients with jaundice are prone to develop a severe anemia for two reasons: malnutrition and hemolysis. They don't eat well, lose weight and develop nutritional anemia, and the retention of bile salts in the blood may cause some hemolysis of red cells. If in addition we assume that cancer was at the back of his symptoms, we have another cause for his anemia.

In summary then, I believe that we have been able to explain all the patient's symptoms on the basis of an obstructive jaundice. We have not tried to find the most likely cause for it, but we can definitely state that he had obstructive jaundice.

HOSPITAL COURSE

Now what happened to him in the hospital? They started him on low-fat diet, which to my thinking was contraindicated. Emaciated as he was, he needed calories and it is very, very hard to feed a lot of calories on a low-fat diet. I also think that he did not get enough fluids. His urine output was 400, 800 and 450 cc. This certainly is not adequate in order to clear his already elevated blood urea nitrogen, especially since the specific gravity of his urine never rose beyond 1.013. It is my estimate that he needed an output of around 2,000 cc. to keep his blood urea nitrogen reduced. Furthermore we find no evidence that anybody gave him vitamin K, not alone for diagnosis but for treatment. In a jaundiced patient with less than 1 per cent of normal prothrombin time, this to me seems a grievous oversight.

In the hospital he became rapidly sicker. His blood urea nitrogen rose to 170 and he developed a sharp pain of some undetermined etiology for which he was given some morphine. When they tried to get an upper gastrointestinal series he did the logical thing: He vomited blood and went into shock from which he could not be aroused. What could have caused this terminal episode of bleeding into his stomach? He could have bled from a tumor invading his duodenum or from a post-bulbar duodenal ulcer, which we mentioned as a cause of his jaundice. If he had developed an acute ulcer on the basis of his biliary obstruction, his malnutrition and his protein deficiency, he could bleed from this one. And he was apparently uremic and uremia is characterized by superficial gastric erosions with bleeding. If we add to these reasons the fact

that he had a prothrombin of less than 1 per cent, we must admit that he had a very adequate reason to bleed.

Now let us discuss the lesion which probably was at the root of the patient's illness. Let us start with the least likely ones. An aneurysm of the biliary or hepatic artery: This one we can forget on the basis that it does not often produce obstruction in the gastrointestinal tract. Post-bulbar ulcer we can omit for two reasons. First, it is a very rare lesion, and second, the man had no history or symptoms antedating his jaundice to suggest that he had a primary ulcer.

Pancreatitis we can argue against since there was no history of pain, especially no correlation between eating and pain, which is so characteristic of pancreatitis. How about a stone in the common duct? There are several facts that are against a stone: First, why did he "drag around" for a month before he became jaundiced? This suggests that he had an underlying systemic illness before he developed his obstruction. A stone should produce prompt obstruction and if he is going to feel sick, it would be later when he began to develop cholangitis and react to his jaundice.

PAIN AS A CRITERION

Can we use pain as a clinical criterion to decide between tumor and stone? In spite of what the textbooks say I do not think you can. Most patients who have a common duct stone will have pains, but maybe one-fourth or one-fifth of them do not have typical colicky pain, and most patients who have cancer with so-called "painless progressive jaundice" will have as a rule a bizarre type of pain, not colicky but rather dull or boring in character. So pain is not going to help us make the distinction between these two lesions.

Seven years after a cholecystectomy is also a fairly long time to develop stones in the common duct. It is possible, but it seems to me unlikely. Also, if we suggest a gallstone as a cause for his jaundice we have got to consider a secondary duodenal ulcer as a reason for his intestinal obstruction. I think that this is less likely than the possibility that he was suffering from cancer.

I think that there are many facts which suggest he had a cancer of either the bile duct, the duodenum or the head of the pancreas. First, the fact that he was sick before he became obstructed suggests that he had a lesion that made him sick and later progressed into obstruction. Second, cancer produces a single lesion which lets us explain his total obstruction. Third, it also explains perhaps the fullness in his right upper quadrant.

"Fullness" is a vague term and sounds like a compromise of two doctors who examined the patient and one said he had a mass and the other said he did not. A tumor might explain it. It certainly explains also the rests of his symptoms: his unremitting jaundice, the ultimate demise, the obstruction presumably of the duodenum. It may even explain his ultimate bleeding.

It seems to me most likely that this man had a cancer, probably of the head of his pancreas, less probably, though I cannot rule it out, a cancer of his common duct or of his duodenum which obstructed his common bile duct incompletely, which gave him a cholangitis and which ultimately led to his death from hemorrhage by erosion of the tumor or by a secondary ulceration. Obstructive jaundice was presumably the basis of his cholemic nephrosis, and inadequate treatment probably hastened the onset of the uremia which played a part in his death.

GENERAL CLINICAL DISCUSSION

QUESTION: How can you explain the afebrile course of his presumed cholangitis?

DR. WATMAN: Yes, that bothers me too, since cholangitis is usually accompanied by chills and fever along with jaundice. But you can have cholangitis without fever and we have seen some cases.

QUESTION: Couldn't you explain both the anemia and the high blood urea nitrogen on the basis of chronic gastrointestinal bleeding?

DR. WATMAN: The anemia certainly. One of the prominent causes of a severe anemia is occult gastrointestinal bleeding. Now blood in the gastrointestinal tract is capable of giving you a blood urea nitrogen of 30 or 40, but not as high as this patient had.

CLINICAL DIAGNOSIS

1. Carcinoma of head of pancreas.
2. Obstructive jaundice with cholangitis.
3. High intestinal obstruction.
4. Cholemic nephrosis.
5. Massive gastrointestinal hemorrhage.

PATHOLOGIC DIAGNOSIS

1. Carcinoma of postsurgical remnant of gallbladder or cystic duct with:
   a) direct extension into liver;
   b) infiltration of common bile duct with stenosis:
2. Metastatic carcinoma to pancreas.
3. Obstructive jaundice.
4. Diverticulum of the duodenum.
5. Cholemic nephrosis.
6. Gastrointestinal hemorrhage.
7. Lobular pneumonia.

PATHOLOGIC DISCUSSION

DR. EMMERICH VON HAAM: I agree that any man who thinks about this case very seriously and considers all these facts would come to the logical conclusion of carcinoma of the pancreas. I want to congratulate Dr. Watman for his excellent discussion and his basically correct diagnosis. I chose this case because the patient developed

his cancer at a site which he thought we had safely eliminated.

The body was well developed, fairly well nourished and deeply jaundiced. There was no ascites or any free fluid in his pleural cavities. The heart was slightly enlarged but otherwise showed no abnormality. The lungs were somewhat heavy and showed an early confluent bronchopneumonia. The spleen was not enlarged and showed no evidence of an infectious splenomegaly as observed in cases of severe cholangitis. The liver weighed 1810 grams. It was deep green in color and the cut surface showed all bile ducts greatly dilated.

The gallbladder itself was absent except for a pouch-like dilatation of the distal portion of the elongated cystic duct which measured 1.5 cm. in diameter. The pouch was firmly attached to the liver bed and when opened was filled with thick mucoid material and white granular, friable tumor tissue. The tumor extended by direct continuity into the surrounding liver tissue, forming a yellow-gray tumor mass 2 to 3 cm. in diameter. There were no metastatic tumor nodules present.

The common bile duct was stenosed 1 cm. below the junction of the right and left hepatic ducts by tumor tissue in the gastrohepatic ligament which completely surrounded the duct but did not invade the mucosa. The lumen of the duct in the stenosed area measured only 2 mm. in diameter. Beyond it the duct appeared narrow but free up to the ampulla of Vater. No stones could be observed. Some of the lymph nodes in the area were enlarged and seemed to contain tumor metastases.

The pancreas was of average size and quite fatty. The head of the pancreas was firm and contained many white tumor nodules. It protruded sharply into the lumen of the duodenum approximately 1.5 cm. proximal to the opening of the ampulla of Vater. The mucosa of the esophagus showed multiple irregular areas of superficial ulceration, particularly in the distal portion.

The gastric mucosa contained many fresh erosions, particularly in the cardia. The lumen was filled with black granular material. The duodenum was filled with similar material and showed a stenosis of the lumen produced by the protruding head of the pancreas. Distal to this a smooth-walled 1 cm. diverticulum was present extending into the pancreas. All intestines were filled with the same tarry fecal material which completely replaced any of the light-colored feces mentioned in the history. Both kidneys were enlarged, soft and deeply icteric. There were no tumor metastases in any distant organs or lymph nodes.

MICROSCOPIC EXAMINATION

Sections through the heart were not significant. Sections through the lungs showed some alveolar hemorrhages and small foci of a very recent confluent bronchopneumonia. Sections through the liver showed the invading tumor as a small-cell adenocarcinoma. No metastases were found. The bile ducts of the liver were dilated and partially fibrosed with many bile thrombi.

The wall of the small pouch described as gallbladder was completely replaced by a small-cell adenocarcinoma. The lymphatics of the hepatoduodenal ligaments contained many tumor thrombi. The head of the pancreas showed extensive tumor metastases. Otherwise the organ was perfectly normal. Sections through the kidneys showed a typical lower nephron nephrosis with many bile casts and tubular cell degeneration.

Based upon our gross and microscopic findings we therefore reached the conclusion that the tumor developed in a re-formed or regenerated gallbladder, a very uncomfortable message for those of us who have thought that their gallbladder has been safely removed. I would like to ask Dr. Watman to explain to us how it can happen that the gallbladder re-forms after a successful cholecystectomy.

GENERAL DISCUSSION

DR. WATMAN: A re-formation of the gallbladder is seen not too uncommonly. When Dr. von Haam described an elongated cystic duct he implied that the person who took out this man's gallbladder played it very safe, but on the other hand left the patient the chance of re-forming a new gallbladder, which then may be subject to all the usual gallbladder diseases. Three or four times I have seen a true small gallbladder that had re-formed from a small remnant of gallbladder left hanging on the cystic duct. It is unusual but by no means a rare bird to find a gallbladder the size of a pigeon egg that has formed because the old gallbladder had not been completely excised.

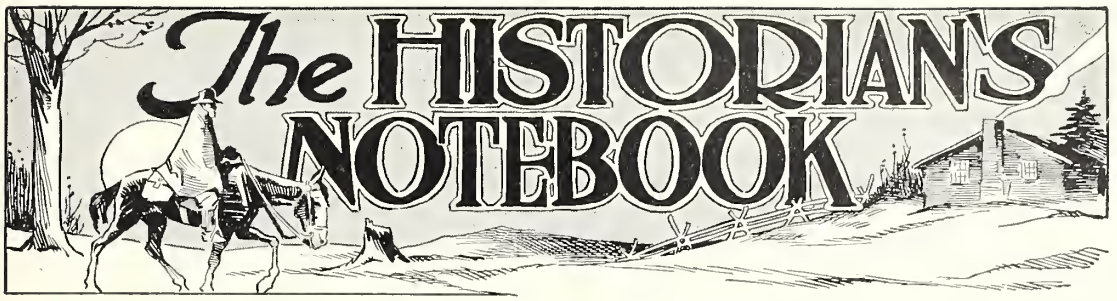
The liver secretes bile under about 300 mm. pressure of water and anything soft and elastic will blow up under this back pressure when the sphincter of Oddi is closed. I suspect that is what happened and I am sorry that I did not consider this possibility.

QUESTION: I was wondering whether you can really call this a re-formation of the gallbladder or if it is just a mechanical dilatation of the distal portion of the cystic duct?

DR. WATMAN: If it were purely a mechanical dilatation, then the thickness of the wall would vary inversely with its size and by the time it got to be the size of a pigeon egg it ought to be paper-thin. Since this is not the case we have to assume that there is always some hyperplasia along with it.

QUESTION: What did the patient bleed from?

DR. VON HAAM: He bled from superficial erosions in the esophagus and the cardia probably caused by his uremia and aggravated by the passing of the stomach tube.



Freudian Dream Interpretation Two Thousand Years Before Freud

Historical and Other Aspects of Dream Interpretation

MAX SEROG, M.D.

PART II

(Concluded from March issue)

OTHER ANCIENT DREAMS

REVIEWING ancient dreams, we become aware that dreams have changed only in their framework, but not in their mechanism. The framework of the dream is accidental and irrelevant; it may change in different eras according to the prevalent ideas of each era. Essential in the dream, is only the dream mechanism, that is, the way in which the primitive dream thinking projects emotions into visual, dramatic reality. This dream mechanism was the same in ancient times as it is today.

Significant and informative in this respect is an ancient dream, related by Heraklides and quoted by Cicero, who calls Heraklides a man of learning and a disciple of Plato. It is a dream of the mother of Phalaris. Cicero reports:

> "She fell asleep and dreamt: While looking at the consecrated images, set up in her home, she saw the statue of Mercury pouring blood from a bowl which it held in its right hand, and the blood, when it touched the ground, welled up and completely filled the house."

The truth of the dream was subsequently established by the inhuman cruelty of her son. At the root of this dream was the still unsubstantiated, but always present, disquieting fear of the mother that the peace of her pious home, in which the gods still had their due place, might be upset by the cruelty of her son. Her troubling fear could be silenced by day. But at night her anxiety emerged uninhibited and created an impressive dream picture, in which she experienced as fulfilled what she still refused to believe.

Submitted October 18, 1956.

The Author

● Dr. Serog, Dayton, is a member of the staff of Dayton State Hospital.

Here, as always, the dream is produced by emotions. But when emotions create a dream, this usually does not occur in a clear and direct presentation, but in an indirect and obscured way (Scherner), which is significant in primitive thinking, and which is the more pronounced, the less the dreamer wants to admit his disturbing emotions to himself. So the dream usually is not what it seems to be. The dream interpretation has to bring out the meaning behind the obvious dream story. Dream interpretation has to turn the manifest into the latent dream, as Freud terms it. Freud attempted to do that on the basis of his theory. However, we have seen that such interpretation can be done only through psychic understanding of the individual dream, not by a general explanation of dreams.

Characteristic for ancient dream interpretation in many respects is a dream of Philipp of Macedonia, the father of Alexander the Great, which Plutarch reports in his *Life of Alexander the Great:*

> "King Philipp of Macedonia sometime after he was married, dreamt that he sealed up the Queen's womb with a seal, the impression of which he thought was a lion. The interpreter thought the dream indicated some doubt of the decent conduct of the Queen. But Alexander of Telmesus—apparently an

authority in dream interpretation at that time —said, the dream only denoted that the Queen was pregnant, for a seal is never put upon anything that is empty, and that the child would prove to be a boy of bold and lion-like courage."

From the reports of ancient dream interpretation it is apparent that it was not very different from what it is today. It used a kind of association technique. Dream phenomena, like condensation and the double meaning of words, were known and utilized. The significance of repeated dreams was also known, as mentioned before.

THE ANCIENT DREAM INTERPRETERS

From the dream just mentioned, it is evident that there were also in ancient times different opinions about the interpretation of a dream. There were also the recognized authorities who were consulted by high personalities in doubtful or important cases. There were, in ancient times, as in all times, among the dream interpreters, the men of routine, who knew their technique, but only their technique; and there were some gifted artists, who, through the art of psychic understanding, through vision and imagination, were able to make their technique useful and successful.

The successful artists probably knew of the psychic roots of their achievements. But even so, for the practical utilization of their abilities, it was better to give their art another aspect. For his clientele the dream interpreter simplified subtle psychic relations, accessible only to psychic understanding, into a flat relationship between dream imagination and real events. In this way he made his activities more impressive and brought them nearer to the mental level of his customers.

THE TWOFOLD ASPECT OF THE DREAM

The deeper we look into ancient dream interpretation, the more we become aware that there are not many essential differences between the old approach and that of today. You may often hear the opinion that in ancient times, dream interpretation was but superstition, and that it is now a scientific procedure. However, we realized that a scientific approach to dream interpretation is neither adequate nor fruitful. We also realized the twofold aspect of the dream, which is one of its essential characteristics (Serog). Along with the twofold aspect of the dream, there always was a twofold approach to the dream. This twofold approach to the dream was always present. It is an historical fact, that at all times a rational and a nonrational approach to the dream existed side by side.

Two thousand years ago, the Roman lawyer, statesman and orator, Marcus Tullius Cicero, published a treatise, *De Divinatione* (on divination), in which he wrote: "If, because of their unreality, we are to have no faith in the visions of the insane, I do not understand why we place any confidence in dreams, which are far more confused." Never was the rational aspect of the dream expressed more strongly and more logically. Cicero recognized that "the sleeper is having the thinking and reasoning portion of his soul languid and inert." Cicero speaks of the ancient belief, handed down to us from mythical times. "This belief," he says, is "a superstition and should be torn out by the root."

Not much later, Plutarch, in an essay "On Superstition," scolded people who believe in dream interpretation and "waste their money and vex themselves by rushing to fortune tellers and such imposters."

The rational approach to the dream is found in all times. There were always those who dismissed the production in dreams as irrelevant nonsense, as it is caused by the discontinuation of our normal mental functions. They refused to ascribe any significance whatsoever to dreams

> "Which are the children of an idle brain
> Begot of nothing, but vain phantasy
> Which is as thin of substance as the air."
>
> —Shakespeare *(Romeo and Juliet)*

However, along with the rational approach to the dream, there always was the conviction that the dream must be more than the haphazard conglomeration of senseless mental fragments. Through the milleniums the belief persisted that there must be some meaning behind the confused dreams; and that the meaning of dreams could be brought to light by its interpretation. This belief runs through the history of mankind so persistently that, although it can have no cause, it must have some motivation.

The belief in the meaning of dreams became substantiated, when, about 2,000 years ago, the psychological approach to the dream began. Plato probably was the first to recognize the fundamental fact of the dream psychology; namely, that the main source of dreams are uninhibited emotions. Plato described the sexual indecencies, the "shamelessness" of the dream. Two thousand years previous to Freud, Plato wrote: "In everyone resides a certain species of desires that are terribly savage and irregular . . . . and this, indeed, becomes manifest in sleep."

From Plato to modern times the psychological aspect of the dream remained predominant. Poets and philosophers continued to contribute to the psychological understanding of the dream. The fundamental role of emotionality in the production of dreams was confirmed and deepened (Maury, Havelock Ellis). Through Freud, dream and dream interpretation again came into the center of attention. Freud made the futile attempt through rationalization of psychic understanding to turn the art of dream interpretation into science. However, as objectionable as Freud's dream theory is, Freud contributed much to the psychic understanding of the dream; he discovered and rediscovered significant dream

phenomena, and he envisioned the psychotherapeutic possibilities of his discoveries. When Freud's dream theory will be forgotten, it will remain one of Freud's great achievements that he made dream interpretation useful for psychotherapy and so gave psychotherapy its finest tool.

THE UNDERSTANDING ART OF DREAM INTERPRETATION

The adequate and fruitful approach to dream interpretation remained always the same, no matter how much and how frequently the attempts to explain the dream changed. Whether these attempts of explanation started from mythic superstition or from undue rationalization, they never were an essential part of the art of dream interpretation. For dream interpretation is an art, resting on psychic understanding.

Dream interpretation always was and still is immediate interpretation of psychic motivation through emotional empathy. Dream interpretation always was and still is understanding art, not explaining science.

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HEALING SPRINGS became fashionable resorts around 1850 for those who sought a cure for female weakness, salt rheum, dyspepsia, nervousness, and scrofula. Drinking generous quantities of mineral water, always warmed to body temperature, became a pastime at the healing springs and later it was possible to send back to one's favorite spring for cases of the water. From the more fashionable springs, however, this was expensive—$9.00 for a case of bottled water.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Saphenous—This term which anatomically designates two veins of the lower limb has a disputed origin. Some authorities feel the term is derived from the Greek word "saphenes" meaning "clear, distinct or manifest." However, this term was not used by the ancient Greek physicians and it is therefore believed by others that the term came into use at a later date and is derived from the Arabic word "safin," meaning "hidden." It is believed that "safin," the Arabic name for these veins, was translated into the Mid-Latin word "saphenna" and that from this we get our modern term "saphenous."

Scoliosis—Literally meaning "a condition of crookedness," this term is composed of the Greek word "skolios" meaning "bent or crooked," plus the suffix "osis," denoting "a condition of." It is an ancient term which was used by Hippocrates for any type of curvature. However, modern usage now restricts the term to designate a lateral curvature of the spine.

Seduce—Literally, "to lead aside or astray; to entice from the path of duty or virtue." The word is derived from the Latin prefix "se," or "aside" and "ducere"—"to lead."

Serratus—Coming from the Latin word "serra" or "saw," this term is applied to muscles arising or inserted by a series of processes resembling the teeth of a saw. An example is the serratus anterior muscle which arises by saw-like processes from the first eight ribs.

Shrapnel—This artillery shell which is capable of wrecking so much human havoc was invented in 1784 by Leutenant Henry Shrapnell, an English artillery officer, who later became a general. The Shrapnell shell was first successfully employed in 1804 at Surinam.

Sigmoid—Literally meaning shaped like the letter *S*, this term is derived from the Greek word "sigma," or the letter *S*, plus "eidos," or "like." The term is used anatomically to describe various *S* shaped structures such as the sigmoid colon or the sigmoid sinus.

Skin—This term designating the natural covering of an animal's body has similar and allied forms in many languages, such as the Icelandic, Norwegian and Swedish word "skinn" and the Danish "skind." These words all probably stem from the Sanskrit root "sku," meaning "to cover."

Sneeze—Coming from a variety of spellings such as "fnese, nese and neeze" this word finally had the letter *s* added to it. The word is probably echoic and is imitative of the sound produced. There are similar words having the same meaning in many other languages.

—HARRY WAIN, M. D., Mansfield, Ohio.

Proceedings of The Council . . .

Heavy Docket Acted Upon At Feb. 23 Meeting: Legislative Issues Reviewed: Committee Reports Considered: Ethical Decisions Made

A REGULAR meeting of The Council of the Ohio State Medical Association was held on Saturday afternoon and evening, February 23, 1957.

On motion made, seconded and carried, the minutes of the previous meetings of The Council held on December 15-16 and February 3 were approved.

MEMBERSHIP STATISTICS

The Executive Secretary reported on membership statistics as follows: Number of OSMA members as of February 22, 6,802; number of OSMA members affiliated with the AMA as of February 22, 5,868.

LEGISLATIVE ISSUES REVIEWED

The Council considered many of the bills pending before the present session of the Ohio General Assembly. It adopted official statements of policy on a majority of the bills or delayed action on others pending more study. The Council instructed the Executive Secretary to get in touch with members of The Council, individually if necessary, concerning policy on bills which may be introduced between the meeting date and the deadline for the introduction of bills—March 5.

A list of proposals considered and actions taken by The Council on Feb. 23 on them, appears elsewhere in this issue.

CARDIAC CLINICS

Mr. Saville presented a report on behalf of the Committee on Public Relations and Economics, reviewing actions taken by that committee on January 20, 1957, and now subject to official action by The Council. The Committee reported that it had considered the following recommendation of the committee on communicable disease and environmental sanitation of the 1956 Ohio Health Commissioners Conference and which was adopted by the conference on September 28, 1956:

> "The Committee on Communicable Disease and Environmental Sanitation recommends that the Health Commissioners Conference support the concept of pediatric cardiac clinics subsidized by the Ohio Department of Health as part of their heart disease program, provided, that the concept of these clinics has the approval of the Ohio State Medical Association. These clinics to be instituted and managed on the local level by the local health commissioner after consultation with his local medical society."

The Committee on Public Relations and Economics pointed out in its report that Dr. Wentworth and Dr. Hartmann of the Ohio Department of Health explained that during the Health Commissioners Conference there had been discussion of the need for additional facilities for pediatric cardiac clinics to supplement the present pediatric cardiac program of the Services for Crippled Children of the Ohio Department of Welfare.

Dr. Hartmann stated that the Department of Welfare had been conducting somewhere between 12 to 15 such diagnostic clinics and that the idea was to supplement this program to fill requests from local medical societies or health departments to meet needs in areas not now being provided with this type of service by the Department of Welfare. Dr. Wentworth said that the Ohio Department of Health at this time had no specific proposal as to how these clinics might be organized and administered.

The report of the OSMA committee advised The Council that it was the unanimous opinion of the committee that the committee was unable to express an opinion on this subject at this time because of the lack of sufficient information. The Council, by official action, approved this action of the committee.

Mr. Saville reported that the Committee on Public Relations and Economics had considered another recommendation from the 1956 Health Commissioners Conference, reading as follows:

> "The Committee on Chronic Disease and Special Programs recommends that the Health Commissioners Conference is in favor of some regulation to register, license or by some system approve or certify medical technologists in Ohio, and that this recommendation be referred to the Ohio State Medical Association."

MEDICAL TECHNOLOGISTS

It was pointed out that requests had been received for review of this general question by the Ohio State Medical Association from representatives of various groups of medical technologists and clinical laboratories.

The report of the Committee on Public Relations and Economics pointed out that six or seven representatives of groups of technologists and clinical laboratories had appeared before the committee to present facts and arguments on the subject.

In its report to The Council the committee cited that it had taken the following action:

"The committee heard reports regarding the problem of inadequate work on the part of some clinical laboratories now operating. The committee is not willing to support the proposal that legislation be enacted to provide for state licen-

sure of clinical laboratories and medical technologists. However, inasmuch as laboratory work is a part of the practice of medicine for which the physician is responsible, it is in the interest of the public and the profession that the Ohio State Medical Association study means of improving the quality of laboratory work available to physicians."

The report and recommendation of the Committee on Public Relations and Economics on this subject was approved by The Council on motion made, seconded and carried. In taking this action The Council also requested the Committee on Public Relations and Economics to make a study as to ways and means of improving the quality of laboratory work available to physicians, a point recommended by the committee.

POLIO IMMUNIZATION

The report of the committee pointed out that it had discussed the polio immunization question at its January 20 meeting and that the views of the committee were consolidated in the following statement:

> "Polio vaccine is now available to everyone. We favor the promotion, by every ethical means, of the widest utilization of polio immunization, as is true of other immunizations. We further believe that the most effective means of accomplishing this is through the offices of practicing physicians."

In the discussion which followed it was pointed out to Council that the polio vaccine policy statement adopted by The Council at its special meeting on February 3 had incorporated the same opinions.

INSURANCE FORMS

Further discussion of the possibility of working out simplified insurance forms generally throughout the state was held by the Committee on Public Relations and Economics at its January 20 meeting, the committee reported. It stated that 14 specific objections cited by the Health Insurance Council to some of the local forms now used in Ohio had been reviewed. The HIC also told the committee that companies which do 74 per cent of the accident and health insurance business in the country are now using some or all of the forms which comply with the standardization program worked out by the HIC and the American Medical Association. A report was received that the Uniform Forms Committee of the HIC would meet in Chicago soon to consider additional proposals to make the standardized forms more acceptable to physicians.

In its report the committee advised The Council that it had taken the following action:

"The committee believes that forms ID-1 and GD-1 represent an improvement though they are not yet as simplified as we had hoped for. We expect further simplification through continued cooperation of the Uniform Forms Committee of the Health Insurance Council and the Committee on Prepayment and Medical Hospital Service of the Council on Medical Service of the American Medical Association. We also expect the Health Insurance Council to intensify its efforts to have more insurance companies adopt the standardized forms, ID-1 and GD-1."

On motion made and seconded, the action of the committee was approved.

HOSPITAL PRIVILEGES

The Council then considered a report from the Judicial and Professional Relations Committee, presented by Executive Secretary Nelson.

The committee reported that it had considered a letter from a member asking whether or not the constitution of the medical staff of a nonprofit hospital can prevent a physician who is duly licensed in Ohio from having staff privileges for the sole reason that he is not a graduate of a medical school in the United States or Canada.

It reported to Council that it had advised the Executive Secretary to write the member as follows, providing The Council agrees:

The question of whether or not action by the medical staff of a hospital precluding a physician from staff privileges because he is not a graduate of a medical school in the United States or Canada is unlawful, is a question which can only be determined by the courts. Any physician believing that such a rule is improper or unlawful should request his own county medical society to investigate the matter and take whatever action it might deem appropriate and feasible. A local society can ask the advice and guidance of the Judicial and Professional Relations Committee of the State Association during its investigation, if such assistance is desired.

On motion duly made, seconded and carried, The Council approved the action of the committee on this question.

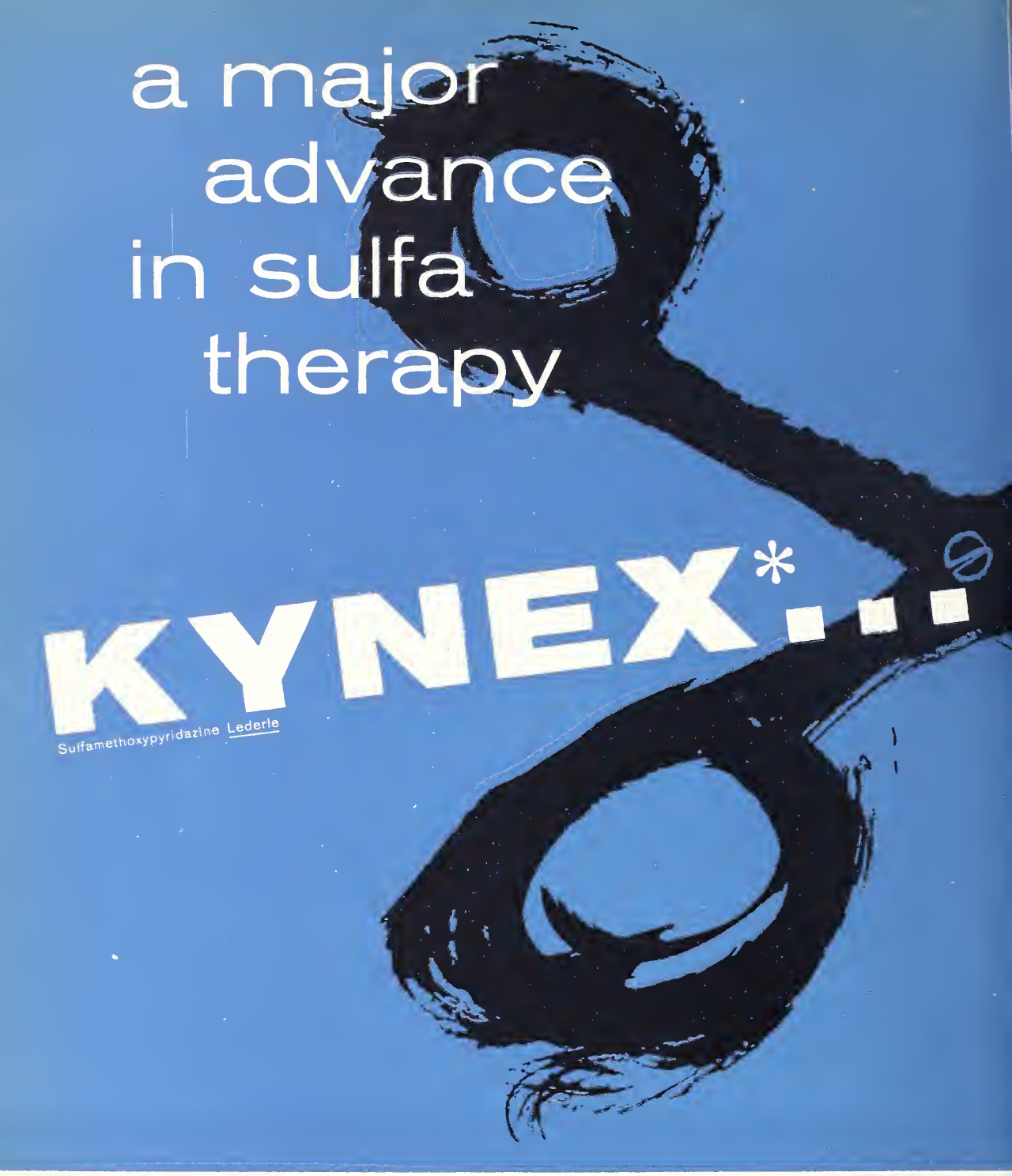
PRIVILEGED COMMUNICATIONS

The report of the committee pointed out that it had received an inquiry for advice on a matter involving privileged communications. The request was in connection with Section 4123.343 of the Revised Code pertaining to reporting of certain diseases and disabilities to the Bureau of Workmen's Compensation.

The committee stated that after considerable study and discussion it had adopted the following statement of policy, subject to action by The Council:

"It would be unethical and unlawful for an industrial physician, or an employer, to report to the State Bureau of Workmen's Compensation the name of a handicapped employee, as defined in Section 4123.343 of the Revised Code of Ohio, without specific consent of such employee to the filing of the report or without having on file a waiver of privilege signed by such employee at

(Continued on Page 436)



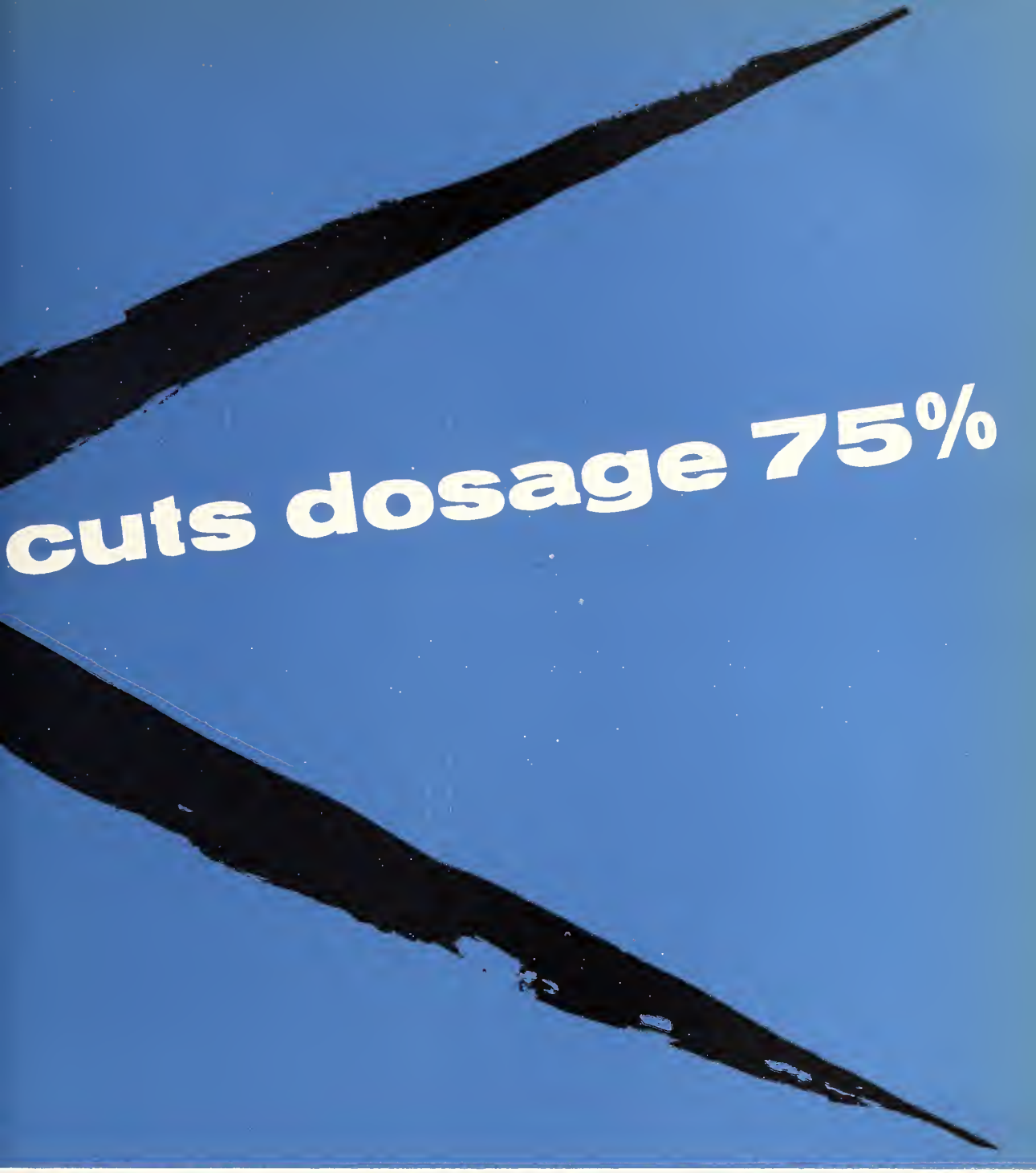
KYNEX is an entirely new, readily soluble, single sulfonamide exhibiting excellent antibacterial action at radically reduced dosage.

KYNEX offers desirable clinical advantages hitherto not obtained by any related drug—

LOW DOSAGE: a total maintenance dose of only 2 tablets daily.

HIGH SOLUBILITY: prompt absorption, adequate diffusion into body fluid and tissue.

PROLONGED ACTION: therapeutic blood levels within the hour, blood concentration peaks within 2 hours—5-10 mg. per cent blood levels persist 24 hours after single oral dose of 1 Gm.



BROAD-RANGE EFFECTIVENESS: KYNEX is particularly efficient in urinary tract infections due to sulfonamide-sensitive organisms, including E. coli, Aerobacter aerogenes, paracolon bacilli, streptococci, staphylococci, Gram-negative rods, diphtheroids and Gram-positive cocci.

SAFETY: KYNEX offers a margin of clinical safety based on low required dosage, solubility, slow excretion rate. Although KYNEX Sulfamethoxypyridazine is a sulfonamide derivative and the usual precautions regarding such drugs should be observed, the low daily dose of 1.0 Gm. is all that is required for the therapeutic blood levels. No increase in dosage is recommended.

CONVENIENCE: The low dose of 1 Gm. (2 tablets) per day offers optimal convenience and acceptance to patients.

EACH TABLET CONTAINS: sulfamethoxypyridazine 0.5 Gm. (7½ grains). **AVAILABLE:** Bottles of 24 and 100 Tablets.

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

Lederle

*Reg. U.S. Pat. Off.

the time he submitted to pre-employment physical examination."

By official vote, The Council approved the action of the committee.

CORPORATE PRACTICE

The Judicial and Professional Relations Committee reported it had before it resolutions from two county medical societies pertaining to corporate practice of medicine. The committee stated that it felt it would be unwise for it to pass judgment on these resolutions because of the many legal and ethical aspects of the subject without hearing testimony from the representatives of the county medical societies which had adopted the resolutions; also testimony from various groups and specialties and others directly interested in the subject.

By official action of The Council, the committee was instructed to arrange a Joint Meeting with the Committee on Hospital Relations of the Ohio State Medical Association and that the committees set up a series of conferences with representatives of the county medical societies submitting the resolutions; representatives of various specialty societies; and representatives of other groups which might be helpful in considering this important question.

MATERNAL HEALTH

Mr. Page reported for the Committee on Maternal Health. He stated that the committee is making substantial progress in reviewing the cases of maternal deaths occurring in Ohio and that reports on certain cases would appear from time to time in *The Journal.*

The committee reported that a project has been initiated to obtain additional information regarding the possible pregnant state of females dying in Ohio between the ages of 18 and 45 years. This project is being carried on in cooperation with the Division of Vital Statistics to give the committee additional information in its study of maternal deaths.

It was pointed out that the committee is now working on a draft of proposed minimum standards of obstetric care and that the final draft will be submitted to The Council for consideration and action at a later date.

The report of the committee was approved by official action.

AMENDMENTS

A communication from the Toledo Academy of Medicine, submitting certain amendments to the Constitution and By-Laws of the Academy which were adopted on January 9, 1957, was read and discussed.

By official action, The Council approved the amendments, but stated that it felt clarifying language should be inserted with regard to the terms of the councilors.

The Council, by official action, approved a new constitution and by-laws recently adopted by the Belmont County Medical Society.

There was further discussion of the revised By-Laws of the Columbus Academy of Medicine pending before The Council for action. The Executive Secretary was advised to inform the Columbus Academy of Medicine that The Council questioned the advisability of the proposed method of naming the chairman of the Academy's Community Health Committee. The Council suggested that officials of the Columbus Academy of Medicine restudy this matter. The Council ordered this matter held over for action at a later date.

MODEL CONSTITUTION

The Council considered again the text of a proposed "model" constitution and by-laws for county medical societies. The proposal was reviewed, item by item, and **by official action** was **adopted, as revised, at this meeting.** The Executive Secretary and Mr. Stichter were instructed to put the document into final shape and send it to all county medical societies for consideration.

AMENDMENT TO OSMA BY-LAWS

Mr. Stichter submitted a proposed amendment to Chapter 11 of the By-Laws of the Ohio State Medical Association, this question having been referred to him for study and action some time ago. Mr. Stichter pointed out that this would clarify the question of what qualifications a physician must possess to be a member of a component county medical society.

By official action, The Council approved submission of the suggested amendment to the House of Delegates at the 1957 Annual Meeting and ordered the proposed amendment published in *The Journal.* See this issue.

OHIO MEDICAL INDEMNITY

A report of the nominating committee to present nominees for the Board of Directors of Ohio Medical Indemnity, Inc., and to be considered at the annual stockholders meeting of O. M. I. in April, was considered.

The committee recommended the renomination of the following and, by official action, The Council approved the nominations made by the committee: Dr. Robert T. Allison, Jr., Akron; Dr. H. M. Clodfelter, Columbus; Dr. R. Dean Dooley, Dayton; Dr. D. W. English, Lima; Dr. Charles N. Hoyt, Chillicothe; Dr. James S. Mathews, Cincinnati; Dr. Carll S. Mundy, Toledo; Dr. George H. Sackett, Cleveland; Dr. L. Howard Schriver, Cincinnati; Dr. C. C. Sherburne, Columbus; Dr. Robert G. Smith, Circleville; Dr. Edmond K. Yantes, Wilmington; Dr. Starling C. Yinger, Springfield; Mr. D. A. Endres, Youngstown; Mr. Clair E. Fultz, Columbus; Mr. Harold W. Slabaugh, Akron; Mr. David L. Temple, Dayton; the Right Reverend Monsignor Maher, Toledo; Mr.

Richard Ross, Columbus; Mr. Fred D. Learey, Columbus; and Mr. James Walker, Columbus.

The Council then, on **motion** duly made, seconded and **carried**, authorized the following to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stockholders meeting of OMI on April 17, 1957, on all business matters coming before that meeting, including the election of directors placed in nomination by The Council as indicated above: Dr. H. M. Clodfelter, Columbus, or Dr. C. C. Sherburne, Columbus, or Mr. Charles S. Nelson, Columbus.

LETTER ON POLIO MATTER

A communication, reading as follows, from the Ohio Academy of General Practice was read and discussed:

> "The Board of Directors of the Ohio Academy of General Practice at a meeting held February 10, 1957, instructed the Executive Secretary to send a letter to you relative to the Polio Immunization program.
>
> "The Board of Directors went on record as opposing the action taken by the Cleveland Academy of Medicine in regard to their Polio Immunization program, and feels that this action is out of line."

By official action, The Council instructed the Executive Secretary to advise the Ohio Academy of General Practice as follows: That the Council, meeting in Columbus on February 3 to discuss the polio immunization question, had reviewed plans instituted in various counties, among which was the plan of the Cleveland Academy of Medicine. The Council felt that the Cleveland plan was similar to some of the other plans throughout the state and appeared to be within the framework for suggestions for polio immunization procedure which were officially adopted by The Council on February 3 and sent to the various county medical societies under date of February 4.

MISCELLANEOUS BUSINESS

A communication from the Columbus Academy of Medicine pertaining to the general subject of practice of medicine by hospitals, was discussed. The communication was referred to the Judicial and Professional Relations Committee which already has this question under consideration.

Communications from Toledo and Akron regarding the proposed organization of a state society of medical assistants were referred to the special committee of Council authorized to consider and act on this question.

A communication from a county medical society, asking that the Ohio State Medical Association give consideration to establishing a method whereby widows of physicians could obtain free hospitalization through some insurance plan or otherwise, was discussed. Council deferred action, pending further study.

By official action, The Council approved a request that the Ohio State Medical Association again act as a co-sponsor of the postgraduate course in pulmonary diseases at Ohio State University next September 27-28. Other groups cosponsoring the project are the Ohio State University College of Medicine, the Ohio Tuberculosis and Health Association, and the Ohio Trudeau Society.

A request from the Ohio Farm and Home Safety Committee, Ohio State Safety Council, for a financial contribution was discussed. The Executive Secretary was instructed to advise that organization that all funds of the Association have been budgeted for other purposes and that therefore, the Association would be unable to make such a contribution.

There being no further business, The Council adjourned.

Attest: CHARLES S. NELSON,
Executive Secretary.

World Gastroenterology Meeting Scheduled in Washington

The World Congress on Gastroenterology will be held at the Sheraton Park Hotel in Washington, D. C., next year, May 25-31, 1958. This congress is being sponsored by the International Society of Gastroenterology and the host organization in this country is the American Gastroenterological Association.

All physicians interested in gastroenterology are invited to attend. Chairman is Dr. Harry L. Bockus. Persons desiring information regarding the program, housing, etc., may direct correspondence to H. M. Pollard, M. D., Secretary General, University Hospital, Ann Arbor, Mich.

Major subjects to be considered at the scientific session are as follows: Peptic ulcer, malabsorption and sprue-like syndromes, nutrition and its effect on the liver and pancreas, intestinal infection and infestation and cancer of the stomach.

Symposium on Alcoholism for Gp's Scheduled in Cleveland

The Subcommittee on Alcoholism of the Academy of Medicine of Cleveland in cooperation with the Cleveland Center on Alcoholism will present a symposium on alcoholism for the Ohio Academy of General Practice and all other interested physicians at St. Luke's Hospital, Shaker Blvd. at East 116th Street, Cleveland, Wednesday, April 17.

This will be a one-day program lasting from 8:30 a. m. until 4:30 p. m. All of the facets of the alcohol problem of interest to physicians will be covered, according to Dr. York N. Pitkin, secretary of the sponsoring committee. Dr. Pitkin's address is 10515 Carnegie Ave., Cleveland.

The program will include a definition of the problem drinker. Sociological, pathological and pharmacological aspects will be discussed. Treatment of both the acute and chronic states will be developed and therapy outlined.

There will be a registration fee of $10 which includes luncheon at the hospital.

AMA Meeting in New York . . .

Many Ohioans Will Participate in Program and Otherwise Attend This Session, June 3-7; Exhibits Will Play Role Among Program Features

PHYSICIANS attending the AMA's 106th Annual Meeting in New York City June 3-7 will find a star-studded revue of exhibits, scientific lectures, medical films and color television programs lined up for their pleasure and enlightenment. Approximately 18,000 physicians from all over the country are expected to participate in this world-famous "short course" in postgraduate medical education. Focal point of the scientific program will be the Coliseum—New York's new exhibition hall—with four floors devoted to technical and scientific exhibits, many of the scientific meetings and the color television program. A number of section meetings plus the scientific film program will be held in hotels near the exhibit hall. Headquarters for the House of Delegates will be the Waldorf Astoria.

SESSIONS ON PROGRESS

An outstanding scientific lecture program is being arranged by the Council on Scientific Assembly. Kicking off the general scientific program on Monday morning, June 3, will be a review of recent progress in surgery while the afternoon session will deal with recent advances in medicine. Tuesday morning's general meeting will feature a discussion on the use and abuse of mood-altering drugs in daily practice.

Formal section meetings will run from Tuesday afternoon through Friday morning. Many of the sections will combine to present special symposiums and panel discussions. The Section on Miscellaneous Topics is arranging sessions on allergy, legal medicine with a mock trial involving the testing of drinking drivers, and methods of improving communication in medicine.

The color television program presenting live surgical procedures from Roosevelt Hospital will again be sponsored in cooperation with Smith, Kline & French Laboratories.

Registration officially opens at the Coliseum Monday at 8:30 a. m. and closes Friday noon. Advance registrations will be accepted Sunday from 12 noon to 4:00 p. m. The exhibit hall will be open to "doctors only" on Tuesday and Wednesday mornings to give physicians an opportunity to circulate more freely among the technical and scientific exhibits. The new Coliseum has many facilities, including air conditioning, escalators, elevators, a cafeteria, and snack bars.

Physicians and their wives should plan now to attend this worthwhile medical conclave. Further details will be published in the *Journal of the AMA*.

INTERNATIONAL FILM PROGRAM

A unique selection of foreign-made medical films will be shown for the first time at the AMA New York session. So far, 20 countries have submitted applications to this "international medical film program." Chief purpose of the program is to bring to the attention of doctors attending the convention some of the outstanding motion pictures produced abroad dealing with many aspects of medicine and surgery. A great many foreign physicians have already indicated an interest in the program.

Another aim will be to afford representatives of the United States and foreign countries the opportunity of discussing the possibilities of lifting existing customs barriers which make it practically impossible to exchange such motion pictures.

This program has been arranged by the AMA in cooperation with Johnson and Johnson, New Brunswick, N. J. Mr. Ralph Creer, director, AMA Motion Pictures and Medical Television, and a special committee have been screening more than 75 applications with an eye to selecting the most unusual and varied program for physicians.

The international exhibition and the regular program of domestic scientific films will be held in separate rooms of the Barbizon Plaza Hotel, located within two blocks of the Coliseum.

TWO NEW AMA EXHIBITS

Two new AMA scientific exhibits designed primarily for physicians will be unveiled at the New York meeting. These displays are being prepared jointly by the Bureau of Exhibits and (1) the Bureau of Health Education and (2) the Council on Foods and Nutrition. Both will be available on a loan basis to medical societies after the Annual Meeting.

(1) "Health Appraisal of the School Child"—presents five factors involved in a complete appraisal program, including teacher observation, screening procedures, dental and medical examinations, and the follow-through. A series of colored slides demonstrating each of these major phases also will be presented. This exhibit will be of interest not only to the medical profession but also to educators and other allied health leaders.

(2) "Foods in Oral Electrolyte Therapy"—designed primarily for the general practitioner who is concerned with electrolyte therapy in the non-hospitalized patient. Purpose of the display is to remind physicians that foods are useful in electrolyte replacement. The exhibit is divided into three major categories: (a) common clinical conditions causing deviation from the normal; (b) examples of foods useful for replacement therapy, and (c) advantages of oral administration of these elements.

Announcing



The Official Program

for the

1957 Annual Meeting

Ohio State Medical Association

Columbus

Tuesday - Thursday . . . . . May 14, 15 and 16

THIS summary of events and features of the Annual Meeting gives readers a gist of what is in store for those who attend. On pages 441, 442, and 443 are day-by-day charts—one each for Tuesday, Wednesday and Thursday. After the reader has scanned these charts, and pinpointed the events in which he is interested, he may turn to the chronological program which follows for details as to subjects and speakers.

Time and Place: Tuesday, Wednesday and Thursday, May 14, 15 and 16. Scientific programs, exhibits and other features will be in the new Veterans Memorial Building, 300 West Broad Street in Columbus. The Annual Banquet and meetings of the House of Delegates will be in the Neil House, 41 South High Street.

Registration: Headquarters will be in the West Entrance Lobby, Ground Floor, of the Veterans Memorial Building. Registration opens at 8:30 a. m. on Tuesday, Wednesday and Thursday. Admission to all sessions and to the exhibits will be by badge secured at time of registration.

Those eligible to register are members of the Ohio State Medical Association (who should present 1957 Membership Cards at time of registration); physicians from other states who are members of their respective state medical associations; residents, interns, medical students, nurses, health workers, and other guests who are

All events of the Annual Meeting will take place in accord with the time prevailing in Columbus the week of the meeting. Columbus ordinarily is on Eastern Standard Time. On May 7 Columbus voters will ballot on a proposal to adopt Daylight Savings Time (fast time). The program will be geared to the time selected by the voters. Check news media for information.

presented at Registration Headquarters by members. The Woman's Auxiliary will provide registration for its members and others who are eligible to attend Auxiliary sessions.

Specialty Section Programs: Many Specialty Sections are conducting programs that are of interest to physicians in the respective section and to those in other branches of practice. Consult daily charts for time and place.

General Sessions: Subjects of broad medical and surgical interest will be discussed at several sessions. Other sessions will be devoted to programs of legal and economic interest to physicians.

Workshop on Medical Writing: Dr. Jonathan Forman, Editor of *The Journal*, will hold this workshop on Wednesday for all physicians interested in writing.

Out-of-State Guest Speakers on Scientific Subjects: The following who are further identified in the detailed program will be guest speakers: Dr. Alexander Aitken, Brookline, Mass.; Dr. George J. Curry, Flint, Mich.; Dr. B. Dixon Holland, Chicago; Dr. Morris J. Nicholson, Boston, Mass.; Dr. Oglesby Paul, Chicago; Dr. Jack A. Pritchard, Dallas, Texas; Dr. William H. Sweet, Boston, Mass.; Dr. Leo J. Wade, New York City; Dr. Wm. L. Williams, Rochester, Minn.; and Mr. John O. Moore, New York.

Guest Participants on Legal and Economic Subjects: Guests who will present legal discussions are R. Brooke Alloway, Columbus; William J. McAuliffe, Jr., Chicago; Earl F. Morris, Columbus; C. Joseph Stetler, Chicago; and Wayne E. Stichter, Toledo. Guest speakers on economic subjects are W. T. Hackett, Columbus, and Lucien O. Hooper, New York City.

Scientific and Educational Exhibits: Medical investigation and clinical studies presented in graphic form. Members of the sponsoring teams will be on hand to discuss the significant points of each exhibit with physicians. Ample time has been provided throughout the program for frequent visits to the exhibits.

Technical Exhibit: Physicians will find a storehouse of educational material in these exhibits. Detail men from leading pharmaceutical and other supply houses will be on hand to discuss latest developments in their respective fields. Physicians should plan to make several visits to these exhibits during the meeting.

House of Delegates: The policy-making body of the State Association meets twice during the Annual Meeting. The first session on Monday evening, May 13, beginning with dinner; the second, on Thursday beginning with luncheon. Both meetings are in the Grand Ballroom of the Neil House.

The Woman's Auxiliary: The Woman's Auxiliary to the Ohio State Medical Association will hold its annual meeting concurrently with the State Association meeting. Sessions will be in the Deshler-Hilton Hotel.

Annual Banquet: Wednesday evening, May 15, is reserved for this special event at the Neil House. Dinner, music, dancing and appropriate entertainment will be in store for members and their ladies. Tickets at $7.50 each may be purchased by mail before the meeting from the Columbus Office of the Association and after the meeting starts at Registration Headquarters in the Veterans Memorial Building. The Honorable C. William O'Neill, Governor of Ohio, and Mrs. O'Neill will be guests of honor at the Banquet.

Specialty Society and Health Organization Meetings: Several organizations have scheduled programs in conjunction with the Annual Meeting. On Monday, May 13, The Ohio State Surgical Association, The Ohio Chapter of the American Academy of Pediatrics and the Ohio State Heart Association will meet. On Wednesday afternoon the Ohio Chapter of the American College of Chest Physicians will meet. Details on these and other meetings as announced appear as a part of this article.

1957 ANNUAL MEETING

Ohio State Medical Association
Veterans Memorial Building
Columbus

TUESDAY, MAY 14

(All sessions at the Veterans Memorial Building unless otherwise indicated.)

TIME	EVENT	PLACE
8:30 A.M.	REGISTRATION OPENS	West Entrance Lobby Ground Floor
9:00 A.M.	OPENING OF SCIENTIFIC AND TECHNICAL EXHIBITS	Exhibition Hall Ground Floor
9:30 to 11:00 A.M.	SECTION ON INDUSTRIAL MEDICINE	Rooms 203-204 Upper Mezzanine Floor
9:30 to 11:00 A.M.	SECTION ON OBSTETRICS AND GYNECOLOGY	Room G-20 Ground Floor
9:30 to 11:00 A.M.	SECTION ON OTORHINOLARYNGOLOGY	Room 201 Upper Mezzanine Floor
9:30 to 11:00 A.M.	JOINT SESSION SECTION ON PHYSICAL MEDICINE SECTION ON SURGERY	Assembly Hall First Floor
9:30 to 11:00 A.M.	SECTION ON UROLOGY	Room G-14 Ground Floor
11:00 to 11:30 A.M.	RECESS FOR TOUR OF EXHIBITS	Exhibition Hall Ground Floor
11:30 A.M. to 12:30 P.M.	CONTINUATION OF MORNING MEETINGS	
2:00 to 3:00 P.M.	GENERAL SESSION "The Doctor and the Law"	Assembly Hall First Floor
3:00 to 3:30 P.M.	RECESS FOR TOUR OF EXHIBITS	Exhibition Hall Ground Floor
3:30 to 5:00 P.M.	GENERAL SESSION "Management of Automobile Injuries"	Assembly Hall First Floor

1957 ANNUAL MEETING

Ohio State Medical Association
Veterans Memorial Building
Columbus

WEDNESDAY MAY 15

(All sessions at the Veterans Memorial Building unless otherwise indicated.)

TIME	EVENT	PLACE
8:30 A.M.	REGISTRATION	West Entrance Lobby Ground Floor
9:00 to 9:30 A.M.	TOUR OF EXHIBITS	Exhibition Hall Ground Floor
9:30 to 11:00 A.M.	JOINT SESSION SECTION ON ANESTHESIOLOGY SECTION ON NEUROLOGICAL SURGERY	Room G-21 Ground Floor
9:30 to 11:00 A.M.	JOINT SESSION SECTION ON GENERAL PRACTICE SECTION ON INTERNAL MEDICINE	Assembly Hall First Floor
9:30 to 11:00 A.M.	SECTION ON OPHTHALMOLOGY	Rooms 206-207 Upper Mezzanine Floor
9:30 to 11:00 A.M.	SECTION ON PEDIATRICS	Rooms 203-204 Upper Mezzanine Floor
9:30 to 11:00 A.M.	SECTION ON RADIOLOGY	Room 201 Upper Mezzanine Floor
10:00 A.M. to 12:00 Noon	WORKSHOP ON MEDICAL WRITING	Room G-14 Ground Floor
11:00 to 11:30 A.M.	RECESS FOR TOUR OF EXHIBITS	Exhibition Hall Ground Floor
11:30 A.M. to 12:30 P.M.	CONTINUATION OF MORNING MEETINGS	
2:00 P.M.	OHIO CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS	Rooms 203-204 Upper Mezzanine Floor
2:00 to 3:30 P.M.	GENERAL SESSION "The Surgical Treatment of Parkinson's Disease" "Mistakes in the Handling of Congestive Heart Failure" "The Problem of Pain: Diagnosis and Treatment"	Assembly Hall First Floor
3:30 to 4:00 P.M.	RECESS FOR TOUR OF EXHIBITS	Exhibition Hall Ground Floor
4:00 to 5:30 P.M.	GENERAL SESSION "The Medical Witness"	Assembly Hall First Floor
7:30 P.M.	ANNUAL BANQUET	Grand Ballroom and Junior Ballroom Neil House

1957 ANNUAL MEETING

Ohio State Medical Association
Veterans Memorial Building
Columbus

THURSDAY MAY 16

(All sessions at the Veterans Memorial Building unless otherwise indicated.)

TIME	EVENT	PLACE
8:30 A.M.	**REGISTRATION**	West Entrance Lobby Ground Floor
9:00 to 10:00 A.M.	**TOUR OF EXHIBITS**	Exhibition Hall Ground Floor
10:00 to 11:00 A.M.	**GENERAL SESSION** "Physicians and Their Investments" "Planning Your Estate"	Assembly Hall First Floor
11:00 to 11:30 A.M.	**RECESS FOR TOUR OF EXHIBITS**	Exhibition Hall Ground Floor
11:30 A.M. to 12:30 P.M.	**GENERAL SESSION** "Persistent Diarrheas"	Assembly Hall First Floor
12:00 Noon	**COMPLIMENTARY LUNCHEON FOR MEMBERS OF THE HOUSE OF DELEGATES** **FINAL BUSINESS SESSION**	Grand Ballroom Mezzanine Floor Neil House
2:00 to 3:00 P.M.	**GENERAL SESSION** "The Malpractice Problem and What's Being Done to Cope With It" "Oral Hypoglycemia Agents"	Assembly Hall First Floor
3:00 to 3:30 P.M.	**RECESS FOR TOUR OF EXHIBITS** (Exhibits Close at 3:30 P. M.)	Exhibition Hall Ground Floor
3:30 to 4:30 P.M.	**GENERAL SESSION** "Antimicrobial Therapy in Special Fields"	Assembly Hall First Floor

MONDAY, MAY 13

6:00 P.M.

HOUSE OF DELEGATES
COMPLIMENTARY DINNER FOR DELEGATES, ALTERNATES, OFFICERS AND COUNCILORS, TO BE FOLLOWED BY BUSINESS SESSION

Grand Ballroom, Mezzanine Floor,
Neil House

ORDER OF BUSINESS

Call to order by Norman O. Rothermich, M.D., Columbus, President of the Columbus Academy of Medicine.

Introduction of the President, Richard L. Meiling, M.D., Columbus.

Consideration of the minutes of the last Annual Meeting (June, 1956, issue of *The Journal.*)

Appointment of Reference Committees by the President.

Nomination and election of Committee on Nominations:

(Nominations from the floor. One representative [delegate] from each Councilor District. The committee shall report to the Second Session, Thursday, 1:00 P.M., its recommendations in the form of a ticket containing nominees for offices, to be filled at this meeting as required under the Constitution and By-Laws.)

Introduction of Resolutions:

(Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committee on Resolutions, and reported back to the House of Delegates at the Thursday afternoon session before any action can be taken. All resolutions must be typewritten and submitted in triplicate.)

Announcements of meeting places of Committee on Nominations and Reference Committees by chairmen of the committees.

Miscellaneous business.

Announcements of Annual Meeting events.
Recess.

Monday Specialty Society and Health Group Meetings

Additional events scheduled on Monday, May 13 include the following, programs of which are printed elsewhere in this issue as indicated:

Annual Meeting of the Ohio State Heart Association, Page 454.

Meeting of the Ohio Chapter, American Academy of Pediatrics, Page 455.

Meeting of the Ohio State Surgical Association, Page 454.

TUESDAY, MAY 14

8:30 A.M.

REGISTRATION OPENS

West Entrance Lobby, Ground Floor
Veterans Memorial Building

9:00 A.M.

OPENING OF SCIENTIFIC AND TECHNICAL EXHIBITS

Exhibition Hall, Ground Floor
Veterans Memorial Building

TUESDAY, MAY 14

9:30 A.M.

SECTION ON INDUSTRIAL MEDICINE

Rooms 203-204, Upper Mezzanine Floor
Veterans Memorial Building

Rex. H. Wilson, M.D., Akron ..... Chairman
James P. Hughes, M.D., Columbus ..... Secretary

9:30 to 9:45

Remarks by the Chairman, Dr. Wilson.

9:45 to 10:30

INDUSTRIAL MEDICINE: 1957

Leo J. Wade, M.D., New York, N. Y., Medical Director, Esso Standard Oil Company; Associate Clinical Professor of Occupational Medicine, New York University Postgraduate Medical School.

10:30 to 11:00

OPPORTUNITIES AND TRAINING IN INDUSTRIAL MEDICINE

William F. Ashe, M.D., Columbus.

11:00 to 11:30

RECESS FOR TOUR OF EXHIBITS

11:30 to 11:40

Business Meeting
Report of Nominating Committee
Election of Officers

11:40 to 12:30

THE PHYSICIAN AND THE SMALLER PLANT (Panel Discussion)

Moderator: Rex. H. Wilson, M.D., Akron.

Medical Policy

Paul A. Davis, M.D., Akron.

Professional Relations

B. Dixon Holland, M.D., Chicago, Ill., Secretary, Council on Industrial Health, American Medical Association.

Compensation Arrangements

E. M. Kline, M.D., Cleveland.

TUESDAY, MAY 14

9:30 A.M.

SECTION ON OBSTETRICS AND GYNECOLOGY

Room G-20, Ground Floor
Veterans Memorial Building

Rollis R. Miller, M.D., Youngstown ..... Chairman
Harry T. Atkins, M.D., Hamilton ..... Secretary

9:30 to 10:45

PELVIC PAIN (Panel Discussion)

Moderator: Leonard H. Biskind, M. D., Cleveland.

Members of Panel: Roger B. Scott, M.D., Cleveland; Robert F. Daly, M.D., Columbus; Lester J. Bossert, M.D., and Douglas P. Graf, M.D., Cincinnati.

10:45 to 11:00

MATERNAL HEALTH IN OHIO

Anthony Ruppersberg, Jr., M.D., Columbus.

11:00 to 11:30

RECESS FOR TOUR OF EXHIBITS

11:30 to 12:30

THE USE OF HYPOTENSIVE DRUGS IN TOXEMIA

Jack A. Pritchard, M.D., Dallas, Texas, Chairman, Department of Obstetrics and Gynecology, Southwestern Medical School of The University of Texas.

12:30 to 12:40

Business Meeting
Report of Nominating Committee
Election of Officers

Jefferson Medical Alumni Reunion

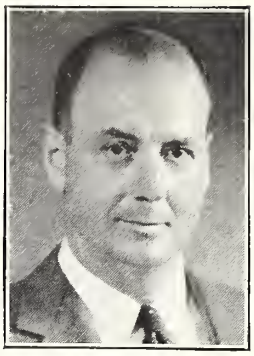
Tuesday, May 14

A get-together has been arranged for Alumni of Jefferson Medical College, their wives and guests who will be in attendance at the 1957 Annual Meeting of the Ohio State Medical Association, Columbus, May 14-16. It will be held at the University Club, 40 South Third Street, beginning with a social hour at 7:00 P. M., dinner at 8:00 P.M., followed by (short) speeches about Jefferson at 9 o'clock. Those planning to attend may assist the committee on arrangements by notifying Dr. Anthony Ruppersberg, 500 South Drexel Avenue, Columbus 9, by mail.

Guest Participants



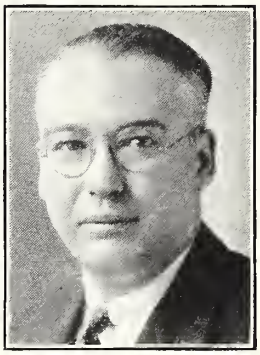
LEO J. WADE, M. D.
New York City



B. D. HOLLAND, M. D.
Chicago



J. A. PRITCHARD, M. D.
Dallas



H. L. WILLIAMS, M. D.
Rochester, Minn.

TUESDAY, MAY 14

9:30 A.M.

SECTION ON OTORHINOLARYNGOLOGY

Room 201, Upper Mezzanine Floor
Veterans Memorial Building

Robert E. Boswell, M.D., Dayton ..... Chairman
Wm. C. Thornell, M.D., Cincinnati ..... Secretary

9:30 to 11:00

THE DIZZY PATIENT (Panel Discussion)

Moderator: Harold E. Harris, M.D., Cleveland.

Members of Panel: G. Douglas Talbott, M.D., Dayton; Bernard Glass, M.D., Lima; William H. Saunders, M.D., Columbus.

11:00 to 11:30

RECESS FOR TOUR OF EXHIBITS

11:30 to 12:30

THE MEDICAL AND SURGICAL MANAGEMENT OF BELL'S PALSY

Henry L. Williams, M.D., Rochester, Minn., Director, Department of Otolaryngology, Mayo Clinic; Professor of Otolaryngology and Rhinology, Mayo Foundation Graduate School, University of Minnesota, Minneapolis.

12:30 to 12:40

Business Meeting
Report of Nominating Committee
Election of Officers

TUESDAY, MAY 14

9:30 A.M.

JOINT SESSION
SECTION ON PHYSICAL MEDICINE
SECTION ON SURGERY

Assembly Hall, First Floor
Veterans Memorial Building

J. A. Helmsworth, M. D., Cincinnati, Co-Chairman
Keith C. Keeler, M.D., Akron ..... Co-Chairman

9:30 to 9:50

MANAGEMENT OF SMALL BOWEL OBSTRUCTION

William E. Abbott, M.D., Cleveland Heights, and Edwin H. Ellison, M.D., Columbus.

9:50 to 10:00

PHYSICAL TREATMENT OF TRAUMATIC KNEE

Keith C. Keeler, M.D., Akron.

10:00 to 10:20

MANAGEMENT OF OCCLUSIVE DISEASE OF MAJOR ARTERIES

A. W. Humphries, M.D., Cleveland, and Louis G. Herrmann, M.D., Cincinnati.

10:20 to 10:30

PHYSICAL TREATMENT OF THE SURGICAL PATIENT IN THE OFFICE

Richard D. Burk, M.D., Columbus.

10:30 to 10:50

MANAGEMENT OF PAPILLARY CARCINOMA OF THE THYROID

Penn G. Skillern, Jr., M.D., Cleveland, and Arthur G. James, M.D., Columbus.

11:00 to 11:30

RECESS FOR TOUR OF EXHIBITS

11:30 to 12:10

ADVANCES IN THE TREATMENT OF CARCINOMA OF THE BREAST (Panel Discussion)

Moderator: Charles M. Barrett, M.D., Cincinnati.

Members of Panel: M. M. Zinninger, M.D., Edward A. Gall, M.D., Jerome Giuseffi, Jr., M.D., Cincinnati.

12:10 to 12:30

Business Meetings of Sections
Reports of Nominating Committees
Elections of Officers

TUESDAY, MAY 14

9:30 A.M.

SECTION ON UROLOGY

Room G-14, Ground Floor
Veterans Memorial Building

Robert A. Keating, M.D., Columbus ..... Chairman
Richard S. Graves, M.D., Dayton ..... Secretary

Guest Participants



G. J. CURRY, M. D.
Flint, Mich.



A. P. AITKEN, M. D.
Brookline, Mass.

9:30 to 10:15

EXSTROPHY OF THE BLADDER: TREATMENT AND END RESULTS

Charles C. Higgins, M.D., Cleveland.

10:15 to 10:30

Discussion.

10:30 to 10:35

LEIOMYOSARCOMA OF THE FEMALE URETHRA—CASE PRESENTATION

E. M. Thomas, M.D., Youngstown.

10:35 to 10:40

PROBLEMS IN THE MANAGEMENT OF DUPLICATED PELVES AND URETERS

Charles A. Anderson, M.D., Warren.

10:40 to 10:45

A RARE KIDNEY TUMOR—CASE REPORT

J. R. Hufschmitt, M.D., Hamilton.

Obstetrics-Gynecology Physicians To Meet in Columbus, May 13

All physicians interested in Obstetrics and Gynecology are invited to attend a dinner meeting on Monday, May 13, in Columbus, sponsored by the Columbus Obstetric and Gynecologic Society, Dr. Harry E. Ezell, Jr., Columbus, secretary. Speaker for the occasion will be Dr. Jack A. Pritchard, chairman of the Department of Obstetrics and Gynecology, Southwestern Medical School of the University of Texas, whose subject will be "Diagnosis and Treatment of Anemia During Pregnancy and Puerperium." The place is the Jai Lai Cafe, 1421 Olentangy River Road, Columbus; the time, 6:30 p. m. Tickets at $6.50 per person are available from Ben E. Jacoby, M. D., 9 Buttles Avenue, Columbus; deadline, May 1.

10:45 to 10:50

PROBLEMS OF HEMATURIA

G. S. Link, M.D., Toledo.

10:50 to 11:00

OPERATION FOR URINARY INCONTINENCE—
(Descriptive Movie)

G. R. Horton, M.D., Springfield.

11:00 to 11:30

RECESS FOR TOUR OF EXHIBITS

11:30 to 12:20

PYELOGRAPHIC CLINIC

Moderator: Charles C. Higgins, M.D., Cleveland.

Members of Panel: David A. Chambers, M.D., Cleveland; John W. Hauser, M.D., Cincinnati; E. W. Cauffield, M.D., Akron.

12:20 to 12:30

Business Meeting

Report of Nominating Committee

Election of Officers

TUESDAY, MAY 14

2:00 P.M.

GENERAL SESSION

Assembly Hall, First Floor
Veterans Memorial Building

Presiding: A Carlton Ernstene, M.D., Cleveland, Chairman, Committee on Scientific Work.

2:00 to 3:00

THE DOCTOR AND THE LAW (Panel Discussion)

Moderator: Wayne E. Stichter, LL.B., Toledo, Legal Counsel, Ohio State Medical Association.

Members of Panel:

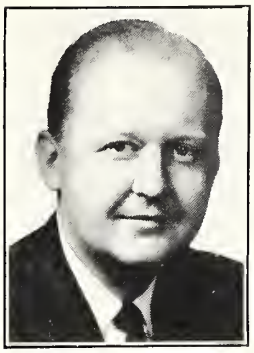
C. Joseph Stetler, LL.B., Chicago, Ill., Director, Law Department, American Medical Association.

Earl F. Morris, LL.B., Columbus, President, Ohio State Bar Association.

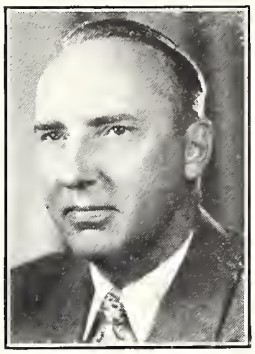
3:00 to 3:30

TOUR OF EXHIBITS

Guest Participants



C. J. STETLER
Chicago



W. E. STICHTER
Toledo



EARL F. MORRIS
Columbus



JOHN O. MOORE
New York City

3:30 to 5:00

SYMPOSIUM ON MANAGEMENT OF AUTOMOBILE INJURIES

Moderator: Frank H. Mayfield, M.D., Cincinnati, Councilor, First District, Ohio State Medical Association.

Crash Injury Prevention

John O. Moore, New York, N. Y., Research Associate, Department of Public Health and Preventive Medicine; Director of Automotive Crash Injury Research, Cornell University Medical College.

Transportation and Immediate Care of the Injured

(Film with Comments by the Speaker)

George J. Curry, M.D., Flint, Mich., Chief, Section for the Surgery of Trauma, Hurley Hospital.

Rehabilitation of the Injured

Alexander P. Aitken, M. D., Brookline, Mass., Professor of Orthopedic Surgery, Tufts College Medical School, Boston.

Question and Answer Period.

WEDNESDAY, MAY 15

8:30 A.M.

REGISTRATION

West Entrance Lobby, Ground Floor
Veterans Memorial Building

9:00 to 9:30

TOUR OF EXHIBITS
Exhibition Hall, Ground Floor
Veterans Memorial Building

WEDNESDAY, MAY 15

9:30 A.M.

JOINT SESSION
SECTION ON ANESTHESIOLOGY
SECTION ON NEUROLOGICAL SURGERY

Room G-21, Ground Floor
Veterans Memorial Building

A. William Friend, M.D., Akron ..... Co-Chairman
Max T. Schnitker, M.D., Toledo ..... Co-Chairman

9:30 to 9:45

HISTORY AND DEVELOPMENT OF HYPOTENSION IN ANESTHESIA AND NEUROSURGERY

Donald E. Hale, M.D., Cleveland.

9:45 to 10:00

HISTORY AND DEVELOPMENT OF HYPOTHERMIA IN ANESTHESIA AND NEUROSURGERY

Sidney Katz, M.D., Cleveland.

10:00 to 10:30

HYPOTENSION AND HYPOTHERMIA FROM THE STANDPOINT OF A NEUROSURGEON

William H. Sweet, M.D., Boston, Mass., Associate Clinical Professor of Surgery, Harvard Medical School.

10:30 to 11:00

HYPOTENSION AND HYPOTHERMIA FROM THE STANDPOINT OF AN ANESTHESIOLOGIST

Morris J. Nicholson, M.D., Boston, Mass., Member, Department of Anesthesiology, Lahey Clinic.

11:00 to 11:30

RECESS FOR TOUR OF EXHIBITS

11:30 to 12:15

HYPOTENSION AND HYPOTHERMIA (Panel Discussion)

Moderator: Jay Jacoby, M.D., Columbus.

Members of Panel: Morris J. Nicholson, M.D., and William H. Sweet, M.D., Boston, Mass.; Hamilton S. Davis, M.D., and W. James Gardner, M.D., Cleveland; Edgar S. Lotspeich, M.D., and A. L. Schwartz, M.D., Cincinnati.

Question and Answer Period.

12:15 to 12:30

CONTINUOUS PERIDURAL ANESTHESIA IN THE EVALUATION OF CHRONIC PAIN AND THE OPERATIVE MANAGEMENT OF ANTEROLATERAL CORDOTOMY

Frank E. Nulsen, M.D., and Robert A. Hingson, Jr., M.D., Cleveland.

Guest Participants



Wm. H. SWEET, M. D.
Boston



OGLESBY PAUL, M. D.
Chicago

12:30 to 12:40

Business Meetings of Sections
Reports of Nominating Committees
Elections of Officers

WEDNESDAY, MAY 15

9:30 A.M.

JOINT SESSION
SECTION ON GENERAL PRACTICE
SECTION ON INTERNAL MEDICINE

Assembly Hall, First Floor
Veterans Memorial Building

Edwin Wm. Burnes, M.D., Van Wert, Co-Chairman
J. Harold Kotte, M.D., Cincinnati ..... Co-Chairman

9:30 to 10:00

CLINICAL MANIFESTATIONS OF HYPERPARATHYROIDISM

Harvey C. Knowles, Jr., M.D., Cincinnati.

10:00 to 10:50

RECOGNITION AND TREATMENT OF CARDIAC EMERGENCIES

Oglesby Paul, M.D., Chicago, Ill., Clinical Associate Professor of Medicine, University of Illinois College of Medicine.

10:50 to 11:00

Business Meetings of Sections
Reports of Nominating Committees
Elections of Officers

11:00 to 11:30

RECESS FOR TOUR OF EXHIBITS

11:30 to 12:30

INVESTIGATION OF THE PALE PATIENT (Panel Discussion)

Moderator: B. K. Wiseman, M.D., Columbus.

Members of Panel: Richard W. Vilter, M.D., Cincinnati; John W. Harris, M.D., Cleveland; L. C. Underwood, M.D., Canton.

WEDNESDAY, MAY 15

9:30 A.M.

SECTION ON OPHTHALMOLOGY

Rooms 206-207, Upper Mezzanine Floor
Veterans Memorial Building

E. J. Wenaas, M.D., Youngstown ..... Chairman
Roscoe J. Kennedy, M.D., Cleveland ..... Secretary

9:30 to 10:45

OFFICE TESTS AND DIAGNOSTIC PROCEDURES FOR GLAUCOMA (Panel Discussion)

Moderator: Roscoe J. Kennedy, M.D., Cleveland.
Members of Panel: E. J. Ballintine, M.D., Cleveland; Gordon H. Pumphrey, M.D., Mt. Vernon; Russell N. Brown, M. D., Dayton.

10:45 to 11:00

Business Meeting
Report of Nominating Committee
Election of Officers

11:00 to 11:30

RECESS FOR TOUR OF EXHIBITS

11:30 to 12:30

DIAGNOSIS AND MODERN MANAGEMENT OF RETINAL DETACHMENT (Panel Discussion)

Moderator: E. J. Wenaas, M.D., Youngstown
Members of Panel: Jacob Moses, M.D., Columbus; Martin J. Cook, M.D., Springfield; Morris L. Battles, M.D., Columbus.

WEDNESDAY, MAY 15

9:30 A.M.

SECTION ON PEDIATRICS

Rooms 203-204, Upper Mezzanine Floor
Veterans Memorial Building

F. Eugene Roach, M.D., Lakewood ..... Chairman
Miner W. Seymour, M.D., Columbus ..... Secretary

SYMPOSIUM ON THE EVALUATION AND SURGICAL TREATMENT OF CARDIAC PROBLEMS IN INFANTS AND CHILDREN

Moderator: Oliver W. Hosterman, M.D., Columbus.

Women Physicians Will Hold Luncheon in Columbus

A noon luncheon for all Ohio women physicians will be held on Wednesday, May 15, in the Sky Room Private Dining Room of the Deshler-Hilton Hotel, Columbus. A fee of $3.00 will include tax and tip. Reservations may be made by writing to Dr. Betsy Blackmore, 2625 Bethel Road, Columbus, secretary-treasurer of the Columbus Medical Women's Association. Reservations also may be made at the OSMA Registration Headquarters in the Veterans Memorial Building until noon on Tuesday.

Emergency Telephone Service Will Be Maintained by Columbus Academy

The Columbus Academy of Medicine will maintain a local information booth and emergency telephone service in the Veterans Memorial Building during the times that program events are in progress. The special telephone number at the booth will be CApital 4-3432. Physicians may wish to leave this number with their secretaries. The physician also should leave information at his home and office as to which hotel he will be in for possible contact at other times. The information booth also will maintain a bulletin board on which names of physicians being called will be posted. Since it has been found impractical to page physicians in assembly halls or on the exhibit floor, members should consult this board frequently for pending calls.

9:30 to 9:45

CARDIAC EVALUATION AND EMERGENCIES OCCURRING IN THE FIRST YEAR OF LIFE

Don M. Hosier, M.D., Columbus.

9:45 to 10:00

CARDIAC EVALUATION AND EMERGENCIES OCCURRING AFTER THE FIRST YEAR OF LIFE

Samuel Kaplan, M.D., Cincinnati.

10:00 to 10:15

SURGERY OF THE GREAT VESSELS

H. William Clatworthy, Jr., M.D., Columbus.

10:15 to 10:35

SURGICAL TREATMENT OF PULMONARY STENOSIS AND ATRIAL DEFECTS

Howard D. Sirak, M.D., Columbus.

10:35 to 10:55

OPEN HEART SURGERY

Donald B. Effler, M.D., Cleveland.

11:00 to 11:30

RECESS FOR TOUR OF EXHIBITS

11:30 to 12:30

Question and Answer Period.

12:30 to 12:40

Business Meeting
Report of Nominating Committee
Election of Officers

WEDNESDAY, MAY 15

9:30 A.M.

SECTION ON RADIOLOGY

Room 201, Upper Mezzanine Floor
Veterans Memorial Building

Sidney W. Nelson, M.D., Columbus — Chairman
George F. Jones, M.D., Lancaster — Secretary

9:30 to 9:50

SPLENOPORTOGRAPHY

William Molnar, M.D., Columbus.

9:50 to 10:10

THE DIAGNOSIS OF INFRA-PULMONARY PLEURAL EFFUSION, WITH PARTICULAR REFERENCE TO EFFUSION SIMULATING ELEVATED DIAPHRAGM

Robert L. Friedman, M.D., Columbus.

10:10 to 10:50

WHEN AND HOW SHOULD RADIOLOGIC EXAMINATIONS BE CARRIED OUT ON PATIENTS WITH UPPER GASTROINTESTINAL BLEEDING

Jack E. Tetirick, M.D., and Sidney W. Nelson, M.D., Columbus.

10:50 to 11:00

Business Meeting
Report of Nominating Committee
Election of Officers

11:00 to 11:30

RECESS FOR TOUR OF EXHIBITS

11:30 to 12:30

OBSTRUCTED INFANTS AND CHILDREN

Wm. H. R. Howard, M.D., and Robert J. Izant, Jr., M.D., Columbus.

WEDNESDAY, MAY 15

10:00 A.M.

WORKSHOP ON MEDICAL WRITING

Room G-14, Ground Floor
Veterans Memorial Building

Conducted by Jonathan Forman, M.D., Columbus, Editor, *The Ohio State Medical Journal*; and Chairman, Advisory Committee to the American Medical Writers' Association.

All Annual Meeting registrants are invited to participate. Special attention will be given to *The Ohio State Medical Journal*. There will be discussion of collecting material; choosing a title; drafting an outline; the value of rewriting; the use of statistics; the use of and verification of references; summary, and conclusions.

2 p. m. Wednesday, Ohio Chapter, American College of Chest Physicians. See pages 455-456.

WEDNESDAY, MAY 15

2:00 P.M.

GENERAL SESSION

Assembly Hall, First Floor
Veterans Memorial Building

Presiding: Louis G. Herrmann, M.D. Cincinnati, Member, Committee on Scientific Work.

2:00 to 2:30

THE SURGICAL TREATMENT OF PARKINSON'S DISEASE

William H. Sweet, M.D., Boston, Mass., Associate Clinical Professor of Surgery, Harvard Medical School.

2:30 to 3:00

MISTAKES IN THE HANDLING OF CONGESTIVE HEART FAILURE

Oglesby Paul, M.D., Chicago, Ill., Clinical Associate Professor of Medicine, University of Illinois College of Medicine.

3:00 to 3:30

THE PROBLEM OF PAIN: DIAGNOSIS AND TREATMENT

Morris J. Nicholson, M. D., Boston, Mass., Member, Department of Anesthesiology, Lahey Clinic.

Guest Participant



M. J. NICHOLSON, M. D.
Boston

3:30 to 4:00

TOUR OF EXHIBITS

Scientific and Technical Exhibits Are Outstanding Features

No small part of the 1957 Annual Meeting is the display of Scientific and Education Exhibits; also the Technical Exhibits, all of which are located in the Veterans Memorial Building for convenient viewing. Experience from previous meetings indicates that physicians spend much time in this area of the meeting place, an excellent witness to their value. Ample time has been provided during the meeting for visits to the Exhibits. Plan to visit them frequently.

On "Medical Witness" Panel



H. E. LeFEVER, M. D.
Columbus



J. D. WILSON, M. D.
Columbus

4:00 to 5:30

THE MEDICAL WITNESS

Opening remarks by C. Joseph Stetler, LL.B., Chicago, Ill., Director, Law Department, American Medical Association.

"The Medical Witness," motion picture produced by The Wm. S. Merrell Company, Cincinnati, in cooperation with the American Medical Association and the American Bar Association, recreating on film a trial where the outcome hinges on the proper presentation of medical testimony. The right and the wrong way to offer medical testimony is vividly and dramatically shown.

Panel Discussion during which highlights of the film will be discussed and questions regarding the appearance of a physician in the courtroom which may not have been answered by the film—or emphasized sufficiently—will be considered.

Moderator: C. Joseph Stetler, LL.B., Chicago, Illinois.

Members of Panel:

Harry E. LeFever, M.D., Columbus, Clinical Professor of Neurosurgery, Ohio State University College of Medicine.

Judson D. Wilson, M.D., Columbus, Associate Professor of Orthopedic Surgery, Ohio State University College of Medicine.

R. Brooke Alloway, LL.B., Columbus, Chairman, Workmen's Compensation Committee, Ohio State Bar Association, and Executive Secretary, Ohio Association of Claimants' Compensation Attorneys.

Wayne E. Stichter, LL.B., Toledo, Legal Counsel, Ohio State Medical Association.

WEDNESDAY, MAY 15

7:30 P.M.

ANNUAL BANQUET AND DANCE

Grand Ballroom and Junior Ballroom
Mezzanine Floor
Neil House

Introduction of Officers and Councilors.

Introduction of the Hon. C. William O'Neill, Governor of Ohio and Mrs. O'Neill.

Remarks by Governor O'Neill.

Introduction of other distinguished guests.

Entertainment.

Reception for Governor and Mrs. O'Neill.

Dancing until 1:00 A.M. to the tunes of Chuck Selby and his band.



Tickets for the Annual Banquet at $7.50 each may be purchased by mail before the meeting from the Headquarters Office of the Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio. Tickets also may be purchased after the meeting has started at the Registration Headquarters, Veterans Memorial Building.

THURSDAY, MAY 16

8:30 A.M.

REGISTRATION

West Entrance Lobby, Ground Floor
Veterans Memorial Building

9:00 to 10:00

TOUR OF EXHIBITS

Exhibition Hall, Ground Floor
Veterans Memorial Building

THURSDAY, MAY 16

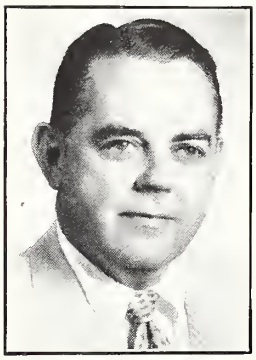
10:00 A.M.

GENERAL SESSION

Assembly Hall, First Floor
Veterans Memorial Building

Presiding: A. Carlton Ernstene, M.D., Cleveland, Chairman, Committee on Scientific Work.

Guest Participants



W. T. HACKETT
Columbus



L. O. HOOPER
New York City

10:00 to 10:30

PHYSICIANS AND THEIR INVESTMENTS

L. O. Hooper, New York, N.Y., Chief Analyst, W. E. Hutton & Company.

10:30 to 11:00

PLANNING YOUR ESTATE

W. T. Hackett, LL.B., Columbus, Vice President and Trust Officer, The Huntington National Bank.

11:00 to 11:30

TOUR OF EXHIBITS

11:30 to 12:30

PERSISTENT DIARRHEAS (Panel Discussion)

Moderator: Austin B. Chinn, M.D., Cleveland, Associate Professor of Medicine, Western Reserve University School of Medicine.

Members of Panel:

Harold P. Roth, M.D., Cleveland, Assistant Professor of Medicine, Western Reserve University School of Medicine.

R. B. Turnbull, M.D., Cleveland, Member of the Staff, Department of Surgery, Cleveland Clinic Foundation.

Warren E. Wheeler, M.D., Columbus, Professor of Pediatrics and Bacteriology, Ohio State University College of Medicine.

Carroll C. Dundon, M.D., Cleveland, Assistant Clinical Professor of Radiology, Western Reserve University School of Medicine.

THURSDAY, MAY 16

12:00 Noon

HOUSE OF DELEGATES COMPLIMENTARY LUNCHEON FOR MEMBERS OF THE HOUSE OF DELEGATES TO BE FOLLOWED BY THE FINAL BUSINESS SESSION

Grand Ballroom, Mezzanine Floor
Neil House

ORDER OF BUSINESS

Consideration of unfinished business from Monday's session of the House of Delegates.

Reports of Reference Committees.

Election of President-Elect. Nomination from the floor.

Report of Committee on Nominations:

(a) **Nominations for The Council.**

(Members of The Council are elected for two-year terms; terms of those representing the even-numbered districts expire in the odd-numbered years.)

To be elected:

Second District—(Incumbent, George A. Woodhouse, M.D., Pleasant Hill.)

Fourth District—(Incumbent, Paul F. Orr, M.D., Perrysburg.)

Sixth District—(Incumbent, Carl A. Gustafson, M.D., Youngstown.)

Eighth District—(Incumbent, Wm. D. Monger, M.D., Lancaster.)

Tenth District—(Incumbent, E. H. Artman, M.D., Chillicothe.)

(b) **Election of Councilor for First District**—(Incumbent, Frank H. Mayfield, M.D., Cincinnati, appointed July 10, 1956 by The Council to succeed Dr. C. T. Atkinson, Middletown, resigned, and to serve until the time of the 1957 Annual Meeting.) At this meeting Councilor to be elected for one year.

(c) **Election of Delegates and Alternates to the American Medical Association**—four Delegates and four Alternates to be elected, each for a two-year term starting January 1, 1958, in compliance with the Constitution and By-Laws of the American Medical Association.

The following incumbent Delegates and Alternates will serve for the remainder of 1957, their terms expiring December 31, 1957, and they may be considered by the nominating committee

(Continued on Next Page)

for re-election for two-year terms starting January 1, 1958:

Paul A. Davis, M.D., Akron
(Delegate)

Edmond K. Yantes, M.D., Wilmington
(Alternate)

Carll S. Mundy, M.D., Toledo
(Delegate)

Paul F. Orr, M.D., Perrysburg
(Alternate)

L. Howard Schriver, M.D., Cincinnati
(Delegate)

E. O. Swartz, M.D., Cincinnati
(Alternate)

C. C. Sherburne, M.D., Columbus
(Delegate)

R. L. Meiling, M.D., Columbus
(Alternate)

Installation of officers for 1957-1958.

Submission of committee appointments by the new President for confirmation by the House of Delegates.

Unfinished or new business.

Adjournment.

THURSDAY, MAY 16

2:00 P.M.

GENERAL SESSION

Assembly Hall, First Floor
Veterans Memorial Building

Presiding: William F. Ashe, M. D., Columbus, Member, Committee on Scientific Work.

Guest Participant

2:00 to 2:30

THE MALPRACTICE PROBLEM AND WHAT'S BEING DONE TO COPE WITH IT

William J. McAuliffe, Jr., LL. B., Chicago, Ill., Law Department, American Medical Association.



Wm. J. McAULIFFE
Chicago

2:30 to 3:00

ORAL HYPOGLYCEMIA AGENTS

Geo. J. Hamwi, M.D., Columbus, Associate Professor of Medicine, Ohio State University College of Medicine.

3:00 to 3:30

TOUR OF EXHIBITS

3:30 to 4:30

ANTIMICROBIAL THERAPY IN SPECIAL FIELDS (Panel Discussion)

Moderator: William R. Culbertson, Cincinnati, Instructor, Department of Surgery, University of Cincinnati College of Medicine.

Members of Panel:

Robert J. Atwell, M.D., Columbus, Chief, Medical Service, Ohio Tuberculosis Hospital.

John R. Haserick, M.D., Cleveland, Department of Dermatology, Cleveland Clinic.

Samuel Saslaw, M.D., Columbus, Associate Professor of Medicine and Assistant Professor of Preventive Medicine, Ohio State University College of Medicine.

Garfield L. Suder, M.D., Cincinnati, Assistant Clinical Professor of Surgery (Urology), University of Cincinnati College of Medicine.

Zeph J. R. Hollenbeck, M.D., Columbus, Clinical Professor of Obstetrics and Gynecology, Ohio State University College of Medicine.

Dayton Seminar on VD Scheduled April 17

As previously announced, a seminar emphasizing treatment of venereal disease in the physician's office will be held at the Biltmore Hotel, Dayton, on April 17, beginning at 9:20 a. m. Joint sponsors are the Ohio Department of Health, the Montgomery County Medical Society, the Ohio Academy of General Practice, Dayton and Montgomery County Social Hygiene Associations and the Dayton Health Department.

Featured speaker will be Dr. Evan Thomas, consultant in VD, New York State Department of Health and emeritus professor of clinical medicine, New York University.

Many Korean Conflict Veterans Will Be Eligible for Ohio Compensation

Some 250,000 veterans of the Korean Conflict are expected to file applications for the Ohio compensation, Director C. W. Goble, of the Korean Conflict Compensation Fund, reported.

Members of the armed forces of the U. S. on active duty between June 25, 1950 and July 19, 1953, who meet requirements of the Ohio program, may be eligible for $10 a month compensation for domestic duty and $15 for foreign duty.

Major veterans organizations have details on the program. The State of Ohio—Korean Conflict Compensation Fund offices are at 293 E. Long St., Columbus 15.

The first Pan American Cancer Cytology Congress will be held at Eden Roc Hotel, Miami Beach, Fla., April 25-29.

MONDAY, MAY 13

OHIO STATE SURGICAL ASSOCIATION
COLUMBUS SURGICAL SOCIETY

DESHLER-HILTON HOTEL

Tom F. Lewis, M.D., Columbus ..... President
George N. Bates, M.D., Toledo ..... Secretary

10:00 A.M.

BOARD OF DIRECTORS MEETING.

12:00 Noon

Columbus Athletic Club

BOARD OF DIRECTORS LUNCHEON

12:00 Noon to 2:00 P.M.

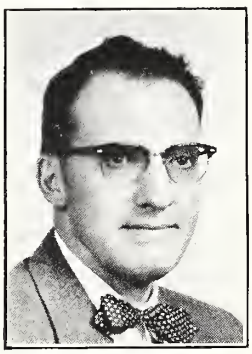
REGISTRATION.

(Banquet tickets available at reception table in Foyer of Main Ballroom; Mac Shaffer, Executive Secretary, Ohio State Surgical Association, in charge. Speaking sessions open to all. A limited number of banquet reservations available for non-members.)

Guest Speakers



JAMES ANDREWS, JR.
New York City



OLIVER SCHROEDER, JR. LL. B.
Cleveland

2:00 to 2:45

INSURANCE COMPANIES' VIEWS ON COMPREHENSIVE HEALTH INSURANCE

James Andrews, Jr., New York, N. Y., Vice-Chairman, Health Insurance Council.

2:45 to 3:30

LEGAL IMPLICATIONS OF FULL COVERAGE HEALTH INSURANCE

Oliver Schroeder, Jr., Cleveland, Professor of Law and Director of Law - Medicine Center, Western Reserve University.

3:30 to 4:00

Foyer

COFFEE BREAK.

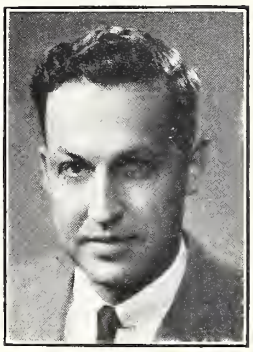
Host—Columbus Surgical Society.

4:00 to 5:00

HOW FIXED FEE SCHEDULES RESULT IN GOVERNMENT CONTROLLED MEDICINE

James L. Doenges, M. D., Anderson, Ind., Past President, American Association of Physicians and Surgeons.

Guest Speaker



JAS. L. DOENGES, M. D.
Anderson, Ind.

5:00 to 6:00

Recess.

6:00 to 7:00

Foyer, Main Ballroom

COCKTAIL HOUR.

7:00 P.M.

BANQUET.

"Life Among the Comic Strip Heroes"

Nicholas P. Dallis, M.D., Toledo, creator of newspaper cartoon strips "Judge Parker" and "Rex Morgan, M.D."

MONDAY, MAY 13

ANNUAL MEETING
OHIO STATE HEART ASSOCIATION

Deshler-Hilton Hotel
Yellow Room, Lower Level

1:45 P.M.

SCIENTIFIC SESSION

Presiding: Dale P. Osborn, M.D., Cincinnati.

1:45 to 2:45

ARTERIOSCLEROSIS

Ancel Keys, Ph. D., Director, Laboratory of Physiological Hygiene, University of Minnesota Medical School, Minneapolis, Minn.

(Continued on Next Page)

2:55 to 4:15

TREATMENT OF HEART FAILURE—A Panel

Moderator: Howard B. Sprague, M.D., Brookline, Mass.

Fluid Electrolytes

John G. Snavely, M. D., Toledo.

Diuretics

Joseph M. Ryan, M.D., Columbus

Digitalis Administration

Harold Feil, M. D., Cleveland.

Diet

J. Harold Kotte, M. D., Cincinnati.

Question and Answer Period.

COMMUNITY HEALTH SECTION

East Foyer, Ballroom Floor

1:45 to 4:30 P.M.

USING COMMUNITY RESOURCES TO FIGHT HEART DISEASE

Presiding: Sewall O. Milliken, Executive Secretary, Columbus Metropolitan Health Council.

COOPERATION—AN ESSENTIAL IN THE HEALTH FIELD

Philip Ryan, Executive Director, National Health Council, New York.

PREVENTION, FACILITIES FOR CARE, REHABILITATION.

Moderator: Sewall O. Milliken.

Panel—Prevention

The Health Department

Robert A. Vogel, M.D., Health Commissioner, Delaware, Madison, Union and Morrow Counties.

The Medical Society

H. M. Clodfelter, M.D., Columbus.

Visiting Nurses Association

Lois L. Booker, R.N., Associate Director, District Nursing Association, Columbus.

Health Education

Robert Yoho, Director, Division of Health and Physical Education, Indiana State Board of Health, Indianapolis.

Panel—Facilities and Services for Care of Medically Indigent Sick

The Hospital—In-Patient and Outpatient

Henry N. Hooper, Administrator, General Hospital, Cincinnati.

Nursing Homes

William Shirkey, President, Ohio Association of Nursing Homes, Elyria.

Aid for Aged

Thomas D. Weiler, Chief, Division of Aid for the Aged, Columbus.

Panel—Rehabilitation

Goodwill Industries

George M. Evans, Executive Director, The Columbus Goodwill Industries, Columbus.

On the Farm

George Morrice, Jr., M.D., Columbus

Employment Services

H. Paul Messmer, Chief, Employment Counseling and Service to the Handicapped, Ohio State Employment Service.

Summary by Moderator—Sewall Milliken.

MONDAY, MAY 13

1:30 P.M.

OHIO CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

Junior Ballroom, Mezzanine Floor

Neil House

Edward V. Turner, M.D., Columbus ..... President

Robert H. Kotte, M.D., Cincinnati ..... Secretary

1:30 to 4:30

SYMPOSIUM ON MENTAL DEFICIENCY

Herman Yannet, M.D., Southbury, Conn., Director of the Southbury Training School, as conductor.

4:30 to 5:30

Business Meeting

(Chapter members only)

7:30 P.M.

Social hour and banquet at Jai-Lai Restaurant, 1421 Olentangy River Road.

WEDNESDAY, MAY 15

2:00 P.M.

ANNUAL MEETING OF OHIO CHAPTER AMERICAN COLLEGE OF CHEST PHYSICIANS

Rooms 203-204, Upper Mezzanine Floor

Veterans Memorial Building

H. I. Humphrey, M.D., Columbus ..... President

F. G. Kravec, M.D., Youngstown ..... Secretary

2:00 to 2:30

PULMONARY FUNGUS DISEASES

Robert J. Atwell, M.D., Columbus, Chief of Medical Service, Ohio Tuberculosis Hospital.

(Continued on Next Page)

2:30 to 3:00

PULMONARY FUNCTION STUDIES

George W. Wright, M.D., Cleveland, Head, Department of Medical Research, St. Luke's Hospital.

3:00 to 3:30

INTRACARDIAC SURGERY UNDER DIRECT VISION

James A. Helmsworth, M.D., Cincinnati, Assistant Professor of Surgery, University of Cincinnati College of Medicine.

3:30 to 3:45

Intermission

3:45

Business Meeting

Ohio Physician Golfers To Meet In Columbus June 21

The annual meeting and tournament of the Ohio State Medical Golfers' Association will be held at the Scioto Country Club, Columbus, on Friday, June 21. This is an all-day outing with tee off time from 9 a. m. to 2 p. m., and the banquet at 7 p. m.

Chairman of the local arrangements committee is Dr. William F. Loveburry, Columbus. Physicians who are not members of the organization and are interested in receiving future notices about activities are invited to write to the secretary, Mr. Robert W. Elwell, executive secretary, Academy of Medicine of Toledo and Lucas County, 3101 Collingwood Blvd., Toledo 10, Ohio.

Woman's Auxiliary Annual Meeting

DESHLER-HILTON HOTEL

MAY 13, 14, 15, 16

Mrs. George T. Harding, III, Columbus, Chairman
Mrs. Charles W. Pavey, Columbus Co-Chairman

MONDAY, MAY 13

10:30 A.M.

Room 310

Budget Committee Meeting.

1:00 P.M.

Grand Ballroom Foyer, Mezzanine

Registration of Board Members.

2:00 P.M.

Room 307

Pre-Convention Board Meeting.

6:00 P.M.

Room 1210

Reception.

7:00 P.M.

Room 1212

Board of Directors Dinner.

TUESDAY, MAY 14

8:30 A.M. to 5:00 P.M.

Room 212

Hospitality Room.

8:30 A.M.

Grand Ballroom Foyer, Mezzanine

Registration.

10:30 A.M.

Room 310

Resolutions Committee and Policy Committee Meeting.

1:00 P.M.

Yellow Room

School of Instruction and Orientation Course. "Who, Why, How and What is The Auxiliary to the Ohio State Medical Association?"

3:00 P.M.

New Governor's Mansion
358 N. Parkview Avenue

Tea and Reception for All Doctor's Wives.

7:00 P.M.

Gavel Club Dinner.

WEDNESDAY, MAY 15

8:30 A.M. to 5:00 P.M.

Room 212

Hospitality Room.

8:30 A.M.

Grand Ballroom Foyer, Mezzanine

Registration.

9:00 A.M.

Yellow Room

Opening Session.

Presiding—Mrs. William H. Evans, Youngstown, President.

Invocation.

Pledge of Loyalty.

Pledge of Allegiance to the American Flag.

(Continued on Next Page)

Greetings.
Address of Welcome.
Response.
Introduction of Convention Chairmen.
Adoption of Rules of Convention.
Report of Roll Call Chairman.
Minutes of 1956 Convention.
Treasurer's Report.
Report of Nominating Committee (first reading).
Report of the Resolutions Committee (first reading).
President's Address.
Election of Nominating Committee.
Election of Delegates to National Convention.
Recess.

12:00 Noon

Grand Ballroom

Luncheon—"Doctor's Day."

2:30 P.M.

Yellow Room

Second Business Session.
Report of Roll Call Chairman.
In Memoriam.

3:00 P.M.

Yellow Room

Playlet, "Doctor—This is Your Wife."
"Auxiliaries in Action."
"Talks In The Round."

7:30 P.M.

Grand Ballroom and Junior Ballroom Neil House

Annual Banquet, Ohio State Medical Association.

THURSDAY, MAY 16

8:30 P.M. to 5:00 P.M.

Room 212

Hospitality Room.

8:30 A.M.

Grand Ballroom Foyer, Mezzanine

Registration.

9:00 A.M.

Yellow Room

Third Business Session.
Presiding—Mrs. William H. Evans.
Report of Roll Call Chairman.
Report of Convention Chairman.
Report of Finance Committee.
Report of Resolutions Committee (second reading).
Report of Nominating Committee (second reading.)
Election of Officers.
Installation of Officers: Address—Mrs. Robert Flanders, President, Woman's Auxiliary to the American Medical Association.
Inaugural Address—Mrs. V. R. Frederick.
Presentation of Past-President's Pin.
Adjournment.

12:30 P.M.

Grand Ballroom

Luncheon honoring Mrs. Robert Flanders, President, Woman's Auxiliary to the American Medical Association; Past Presidents and Honorary Members of the Woman's Auxiliary to the Ohio State Medical Association; State Board Members; Out-of-State Guests; County President.

2:30 P.M.

Room 307

Post-Convention Board Meeting.
Presiding—Mrs. V. R. Frederick.

OSMA Well Represented At AMA Conference

The Ohio State Medical Association was well represented at the AMA-sponsored 12th annual National Conference on Rural Health in Louisville, Ky., March 7-9.

Among those attending were Dr. H. T. Pease, Eleventh District Councilor, and Mrs. Pease, Wadsworth; Dr. and Mrs. J. Martin Byers, Greenfield; Dr. and Mrs. E. G. Caskey, Mineral Ridge; Dr. and Mrs. Robert E. Reiheld, Orrville; Dr. and Mrs. Harry Wain, Mansfield; Dr. V. R. Frederick, Urbana; and Charles W. Edgar, Jr., OSMA administrative assistant.

With the exception of Drs. Pease and Wain, those physicians who attended are members of the OSMA Committee on Rural Health. Dr. Pease is a former committee member. Dr. Wain was one of the conference speakers, his topic being "Rural-Urban Problems." Scheduled for a prominent role in the conference but unable to attend because of illness in his family was Dr. Carll S. Mundy, of Toledo, vice-chairman of the AMA Council on Rural Health and a member of the OSMA Committee on Rural Health. His prepared address was read at the meeting.

Subjects covered at the conference included modern day medical care, the impact of modern living, rural economics in relation to health, the migrant labor health problem, rural aspects of problems of the aging, the economic situation in agriculture, rural hospitals, and others. Principal speaker for the conference was L. E. Burney, M. D., surgeon general, Department of Health, Education and Welfare, who addressed the annual conference banquet on "Changing Scenes in Rural Health."

SCIENTIFIC AND EDUCATIONAL EXHIBITS

The Scientific and Educational Exhibits in the Exhibit Hall of the Veterans Memorial Building will be open daily from 9:00 A. M. to 5:30 P. M. on Tuesday, May 14, and Wednesday, May 15; and from 9:00A. M. to 3:30 P. M. on Thursday, May 16.

DIFFERENTIAL DIAGNOSIS AND MANAGEMENT OF THE RED EYE

William H. Havener, M. D., Department of Ophthalmology, Ohio State University College of Medicine.

REHABILITATION OF THE YOUNG CARDIAC

Ohio State Heart Association, Columbus.

ARTERIOSCLEROSIS OF THE ABDOMINAL AORTA

John Storer, M. D., Huron Road Hospital, Cleveland.

RESULTS OF ARTERIAL GRAFTING

A. W. Humphries, M. D., Victor G. deWolfe, M. D., Fay A. LeFevre, M. D., Cleveland Clinic.

MUSCULAR DYSTROPHY: TYPES — DIFFERENTIAL DIAGNOSIS — CHARACTERISTICS

Muscular Dystrophy Associations of America, Inc., New York, N. Y.

IMMUNIZE AGAINST POLIOMYELITIS

Thomas M. Rivers, M. D., National Foundation for Infantile Paralysis, New York, New York.

FRACTURES OF THE CALCANEUS

Arnold D. Piatt, M. D., Gerald A. Erhard, M. D., William V. Banning, M. D., Newark.

SECONDARY CHANGES IN KNEE DYSFUNCTION IN GERIATRIC PATIENTS

Keith C. Keeler, M. D., The Rehabilitation Center of Summit County, Inc., Akron.

SPEECH THERAPY FOR THE BRAIN INJURED

Keith C. Keeler, M. D., The Rehabilitation Center of Summit County, Inc., Akron.

TOLEDO UTERINE CANCER DETECTION PROGRAM

E. L. Burns, M. D., T. W. Gorski, Ph. D., Mercy Hospital; the Academy of Medicine of Toledo and Lucas County; Cancer Cytology Research Fund of Toledo, Inc., Toledo.

THE USE OF A NEW RESPIRATORY INDEX FOR THE EVALUATION OF XANTHINE DRUGS IN CHRONIC PULMONARY DISEASE

S. William Simon, M. D., Brown General Hospital, Veterans Administration Center, Dayton.

HIATUS HERNIA: SURGICAL ASPECTS

Maurice G. Buckles, M. D., George Medina, M. D., Columbus.

DEGENERATIVE VASCULAR DISEASE OF DIABETES MELLITUS

J. M. B. Bloodworth, Jr., M. D., Department of Pathology; Geo. J. Hamwi, M. D., Department of Medicine, Ohio State University College of Medicine.

COORDINATION-SERVICES FOR PRESCHOOL BLIND CHILDREN

Coordinator-Services for Preschool Blind Children, Division of Social Administration; Ohio Department of Welfare; Ohio Department of Health; Ohio Department of Education, Columbus.

CONGENITAL ANOMALIES AMENABLE TO PLASTIC AND RECONSTRUCTIVE SURGERY

Byron E. Boyer, M. D., Mary M. Martin, M. D., Cincinnati.

CARDIAC CATHETERIZATION AND SELECTIVE CARDIOANGIOGRAPHY IN NON-CYANOTIC CONGENITAL HEART DISEASE and CARDIAC CATHETERIZATION AND SELECTIVE CARDIOANGIOGRAPHY IN CYANOTIC CONGENITAL HEART DISEASE

F. Mason Sones, Jr., M. D., Cleveland Clinic Foundation.

YOUR BLOOD GIFT

Charlotte Winnemore, M. D., Director, Columbus Regional Red Cross Blood Program; and Thos W. Geoghegan, M. D., Director, Cleveland Regional Red Cross Blood Program.

MONTGOMERY COUNTY SOCIETY FOR CANCER CONTROL

Montgomery County Medical Society, Dayton.

THE HOMOGRAFT BANK: A COMMUNITY FUNCTION

Montgomery County Medical Society Central Homograft Unit, and Medical Foundation of the Montgomery County Medical Society, Dayton.

ALCOHOL TESTS FOR DRINKING DRIVERS

American Medical Association and National Safety Council, Chicago.

LOWER INTESTINAL OBSTRUCTION IN INFANCY AND CHILDHOOD

Robert J. Izant, Jr., M. D., William H. R. Howard, M. D., and Dale H. Magleby, M. D., Departments of Surgery and Radiology, Ohio State University College of Medicine, and the staff, The Children's Hospital, Columbus.

RECONSTRUCTION OF UPPER GASTROINTESTINAL TRACT WITH SEGMENTS OF COLON

William E. Neville, M. D., George H. A. Clowes, Jr., M. D., and Department of Surgery, Western Reserve University School of Medicine, City Hospital, Cleveland.

CYTOLOGY IN DIAGNOSIS AND RESEARCH

Emmerich von Haam, M. D., G. Ceelen, M. D., D. Scarpelli, M. D., A. Horva, M. D., C. Gantt, M. D., M. S. N. Murphy, M. D., E. Miller, M. D., Department of Pathology, Ohio State University.

INFECTED INTERVERTEBRAL DISKS: CLINICAL AND ROENTGENOGRAPHIC FEATURES

Arthur L. Scherbel, M. D., W. James Gardner, M. D., Cleveland Clinic Foundation.

CLINICAL EVALUATION OF OPEN HEART SURGERY

Earle B. Kay, M. D., David Mendelsohn, M. D., Thomas MacKrell, M. D., John MacKrell, M. D., F. S. Cross, M. D., H. A. Zimmerman, M. D., and St. Vincent Charity Hospital, Cleveland.

PERINATAL HEALTH STUDY

J. H. Williams, M. D., Chairman; T. E. Shaffer, M. D., Co-Chairman; W. E. Newton, Jr., M. D., Pathologist, Franklin County Perinatal Health Study, Columbus.

OBLITERATIVE ARTERIAL DISEASE OF THE LOWER EXTREMITY

John J. Cranley, M. D., Raymond J. Krause, M. D., Cincinnati.

ULCERS OF THE LEGS DUE TO VENOUS INSUFFICIENCY

John J. Cranley, M. D., Raymond J. Krause, M. D., Cincinnati.

QUEST FOR FERTILITY

Planned Parenthood League of Ohio, Region IV, Columbus.

ACUTE CHOLECYSTITIS

Stanley O. Hoerr, M. D., W. V. Martinez, M. D., A. A. Zavaleta, M. D., Cleveland, Clinic.

OCCUPATIONAL THERAPY AS REHABILITATION IN COLUMBUS

Richard D. Burk, M. D., Medical Director, Ohio Rehabilitation Center, University Hospital; Dorothy E. Whitford, OTR, Ohio Occupational Therapy Association, Columbus.

THE RELATIONSHIP OF HYDROCEPHALUS TO MYELOMENINGOCELE AND HYDROMYELIA

W. James Gardner, M. D., Jorge Angel, M. D., Cleveland Clinic Foundation.

PRACTICAL APPLICATIONS OF CLINICAL ELECTROENCEPHALOGRAPHY

Milton M. Parker, Ph. D., M. D.; Robert P. Calhoon, B. S.; White Cross Hospital; University Hospitals, Columbus.

MIGRAINE—"PANDORA'S BOX"

Keith W. Sheldon, M. D.; James H. MacCleod, M. D.; St. Vincent Charity Hospital, Cleveland.

MODERN MEANS FOR CELL RESEARCH

J. R. Meyer-Arendt, M. D., Department of Pathology, Ohio State University, Columbus.

ENZYMES IN MODERN MEDICINE

Walter J. Frajola, Ph. D., University Hospital, Columbus; Herman A. Hoster Research Laboratory, Department of Medicine, Ohio State University.

APPLICATIONS OF ELECTRON MICROSCOPE IN MODERN MEDICINE

Walter J. Frajola, Ph. D., University Hospital, Columbus; Herman A. Hoster Research Laboratory, Department of Medicine, Ohio State University.

TRANSCAROTID AORTOGRAPHY

William Molnar, M. D., Joseph M. Ryan, M. D., Karl P. Klassen, M. D., Sidney W. Nelson, M. D., Ohio State University Health Center.

AIRWAY OBSTRUCTION

C. Ziegler, M. D., J. Varney, M. D., Jay Jacoby, M. D., University Hospital, Ohio State University.

RADIOISOTOPES IN GYNECOLOGY AS APPLIED IN PELVIC MALIGNANCIES

John C. Ullery, M. D., John H. Holzaepfel, M. D., University Hospital, Columbus; Department of Obstetrics and Gynecology, Ohio State University.

VENTRICULAR JUGULAR SHUNT

Martin P. Sayers, M. D., Department of Neurosurgery, Children's Hospital, Columbus.

THE USE OF SELECTIVE CARDIAC ARREST IN THE REPAIR OF INTRACARDIAC DEFECTS

W. H. Falor, M. D., Clifford Boeckman, M. D., Jean Vallee, M. D., Akron City Hospital.

AIDS FOR THE PHYSICIAN WORKING WITH CRIPPLED CHILDREN

The Ohio Society for Crippled Children, Columbus.

AMA Sex Pamphlets Are Now In Book Form

E. P. Dutton and Company is now publishing in book form the series of sex pamphlets first prepared and distributed by the Joint Committee on Health Problems in Education of the National Education Association and the AMA. The publishing company will concentrate on advertising and merchandising the series for over-the-counter sales to the public. The original pamphlets, however, will continue to be distributed to educational, medical, and public health agencies.

Orthoptic Training Available At Ohio State

The Ohio State University, Department of Ophthalmology will begin the next orthoptic course in September. This is an intensive nine month program, combining basic science and practical work. No fees are charged, but the student must support herself during the training period. Inquiries should be directed to Dr. William H. Havener, Department of Ophthalmology, Ohio State University, Columbus.

DELEGATES AND ALTERNATES

Counties	Delegates	Alternates
FIRST DISTRICT		
ADAMS	S. J. Ellison	R. L. Woodyard
BROWN	Donald L. Domer	Charles H. Maly
BUTLER	Neil Millikin	John F. Borelli
	Walter A. Reese	William U. Neel
CLERMONT	Carl A. Minning	John T. Crone
CLINTON	Edmond K. Yantes	Thomas M. Faehnle
HAMILTON	Robert J. Anzinger	Charles D. Bahl
	Harry K. Hines	Henry C. Beekley
	Richard B. Homan	Joseph J. Bell
	Charles W. Hoyt	F. Paul Duffy
	J. Robert Hudson	Virginia M. Esselborn
	Daniel V. Jones	Robert E. Howard
	J. Harold Kotte	Roy L. Kile
	Robert D. Mansfield	Howard F. C. Pfister
	William A. Moore	Stuart A. Schloss
	Virgil A. Plessinger	Harry C. Shirkey
	Carl F. Vilter	William C. Thornell
HIGHLAND	J. Martin Byers	Glendon E. Parry
WARREN	O. L. Layman	George Van Harlingen
SECOND DISTRICT		
CHAMPAIGN	Isador Miller	V. R. Frederick
CLARK	J. Harold Shanklin	William H. Crays
	Ray M. Turner	E. W. Schilke
DARKE	Maurice M. Kane	P. H. Mulder
GREENE	Paul D. Espey	C. G. McPherson
MIAMI	Dale A. Hudson	E. T. Pearson
MONTGOMERY	H. R. Cammerer	Kenneth D. Arn
	R. Dean Dooley	Lynne E. Baker
	T. L. Light	Robert M. Craig
	R. E. Pumphrey	W. H. Hanning
	Ned D. Shepard	Charles L. Kagay
PREBLE	C. J. Brian	A. L. Ross
SHELBY	George J. Schroer	James W. Tirey
THIRD DISTRICT		
ALLEN	Fred P. Berlin	Walter C. Beery
	Donald W. English	Margaret E. Belt
AUGLAIZE	Elizabeth Y. Kuffner	H. S. Wolfe
CRAWFORD	Mart L. Helfrich, Jr.	Mart L. Helfrich, Sr.
HANCOCK	Harold K. Treece	R. Grant Janes
HARDIN	Floyd M. Elliott	Louis A. Black
LOGAN	H. L. Mikesell	Douglas W. Beach
MARION	Daniel M. Murphy	M. S. Olson
MERCER	George H. McIlroy	
SENECA	Walter A. Daniel	Henry L. Abbott
VAN WERT	Edwin W. Burnes	A. C. Diller
WYANDOT	H. K. Van Buren	F. M. Smith
FOURTH DISTRICT		
DEFIANCE	J. F. Holtzmuller	William S. Busteed
FULTON	Richard K. Vogel	Benjamin Reed
HENRY	Thomas F. Tabler	E. C. Winzeler
LUCAS	Warren A. Baird	Henry A. Burstein
	J. Lester Kobacker	Henry D. Cook
	A. J. Kuehn	Edward F. Ockuly
	Frank F. A. Rawling	Maurice A. Schnitker
	Howard E. Smith	R. P. Whitehead
	G. H. Start	Charles S. Wohl
OTTAWA	George A. Boon	Cyrus R. Wood
PAULDING	D. E. Farling	
PUTNAM	Milo B. Rice	Donald B. Lucas
SANDUSKY	R. A. Borden	
WILLIAMS	Paul G. Meckstroth	John R. Riesen
WOOD	Roger A. Peatee	H. E. Whitacre
FIFTH DISTRICT		
ASHTABULA	S. A. Burroughs	James G. Macaulay
CUYAHOGA	James O. Barr	Eduard Eichner
	J. L. Bilton	James A. Gavin
	F. L. Browning	John A. Kenney, Jr.
	John H. Budd	A. Macon Leigh
	C. A. Colombi	Frank J. Rack
	A. C. Corcoran	B. B. Sankey
	E. A. Ferreri	Edward W. Shannon
	John J. Grady	Leo H. Simoson
	H. A. Haller	
	John B. Hazard	
	H. D. Iler	
	C. R. Jablonoski	
	F. R. Kelly	
	Thomas D. Kinney	
	M. H. Lambright, Jr.	
	P. A. Mielcarek	
	P. J. Robechek	
	J. M. Rossen	
	Paul J. Schildt	
	Edwin L. Smith	
GEAUGA	Dale J. Hawk	
LAKE	Benjamin S. Park	James G. Powell

Counties	Delegates	Alternates
SIXTH DISTRICT		
COLUMBIANA	John A. Fraser	J. Keith Rugh
MAHONING	Paul J. Mahar	H. P. McGregor
	Asher Randell	C. W. Stertzbach
	Fred G. Schlecht	Craig C. Wales
PORTAGE	Robert E. Roy	Arthur L. Knight
STARK	A. E. Boyles	Mark G. Herbst
	R. L. Rutledge	Keith C. Noble
	R. E. Tschantz	W. A. White, Jr.
SUMMIT	Philip B. deMaine	W. H. Allison
	Donald I. Minnig	R. J. Burkhard
	Harold E. Muller	Paul E. Cheek
	H. O. Musser	Donald M. Traul
	Carl C. Nohe	Maurice G. Wince
TRUMBULL	E. G. Caskey	Joseph M. Gledhill
	E. R. Westbrook	Ralph H. Jamison
SEVENTH DISTRICT		
BELMONT	B. C. Diefenbach	James H. Carson
CARROLL		
COSHOCTON	Norman L. Wright	Robert R. Johnson
HARRISON	G. E. Henderson	Dwight C. Pettay
JEFFERSON	Carl F. Goll	S. L. Burkhardt
MONROE	A. R. Burkhart	Byron Gillespie
TUSCARAWAS	J. W. Hamilton	R. E. Rinderknecht
EIGHTH DISTRICT		
ATHENS	Charles F. Jividen	Eleanora Schmidt
FAIRFIELD	Chester P. Swett	J. L. Kraker
GUERNSEY	James A. L. Toland	Robert A. Ringer
LICKING	R. G. Plummer	J. Fleek Miller
MORGAN	Henry Bachman	A. A. Coulson
MUSKINGUM	A. C. Ormond	J. Herbert Bain
NOBLE	Edward G. Ditch	Norman S. Reed
PERRY	Charles E. Bope	Michael P. Clouse
WASHINGTON	Ford E. Eddy	K. E. Bennett
NINTH DISTRICT		
GALLIA	John J. Schwab	Norman Goldstein
HOCKING	C. T. Grattidge	Owen F. Yaw
JACKSON	C. C. Fitzpatrick	C. S. Hambrick
LAWRENCE	George N. Spears	V. W. Blagg
MEIGS	Roger P. Daniels	Selim J. Blazewicz
PIKE	A. M. Shrader	Paul H. Jones
SCIOTO	O. D. Tatje	W. M. Singleton
VINTON	H. D. Chamberlain	Richard E. Bullock
TENTH DISTRICT		
DELAWARE	Robt. S. Caulkins, Jr.	James C. Parker
FAYETTE	James E. Rose	J. M. Herbert
FRANKLIN	Perry R. Ayres	Drew J. Arnold
	Mel A. Davis	William F. Bradley
	Edward W. Harris	Wiley L. Forman
	Robert M. Inglis	Charles W. Matthews
	Charles W. Pavey	Jack W. Miles
	Judson D. Wilson	Clark P. Pritchett
		William P. Smith, Jr.
KNOX	Henry T. Lapp	R. S. Lord
MADISON	Sol Maggied	William T. Bacon
MORROW	J. P. Ingmire	F. H. Sweeney
PICKAWAY	F. W. Anderson	J. M. Hedges
ROSS	Ralph W. Holmes	Robert E. Swank
UNION	E. J. Marsh	Fred C. Callaway
ELEVENTH DISTRICT		
ASHLAND	M. D. Shilling	
ERIE	E. J. Meckstroth	George A. Stimson
HOLMES	N. P. Stauffer	A. J. Earney
HURON	O. J. Nicholson	J. V. Emery
LORAIN	Ben V. Myers	Robert L. Adair
	G. R. Wiseman	A. L. Berman
MEDINA	Nevin J. M. Klotz	C. E. Whitacre
RICHLAND	H. G. Knierim	R. H. Barnes
	P. O. Staker	D. W. DeWald
WAYNE	Adrian J. Hartzler	Albert B. Huff

OFFICERS

Pres.	R. L. Meiling	Treas.	Geo. J. Hamwi
Pres.-Elect	Robert S. Martin	Past-Pres.	Charles L. Hudson

COUNCILORS

District		District	
First	Frank H. Mayfield	Seventh	Robert E. Hopkins
Second	G. A. Woodhouse	Eight	Wm. D. Monger
Third	James R. Jarvis	Ninth	C. L. Pitcher
Fourth	Paul F. Orr	Tenth	E. H. Artman
Fifth	George W. Petznick	Eleventh	H. T. Pease
Sixth	Carl A. Gustafson		

TECHNICAL EXHIBITORS

EXHIBITION HALL, GROUND FLOOR, VETERANS MEMORIAL BUILDING

Open from 9:00 A.M. to 5:30 P.M. on Tuesday, May 14, Wednesday, May 15, and from 9:00 A.M. to 3:30 P.M. on Thursday, May 16

Exhibitor	Address	Booth No.
Abbott Laboratories, North Chicago, Ill.		84
Aloe, A. S., Company, St. Louis, Mo.		38-39
Ames Company, Inc., Elkhart, Ind.		65
Arnar-Stone Laboratories, Inc., Mount Prospect, Ill.		18
Audio-Digest Foundation, Glendale, Cal.		81
Ayerst Laboratories, New York, N. Y.		31
Baby Development Clinic, Chicago, Ill.		69
Baker Laboratories, Inc., The, Cleveland, O.		35
Burroughs Wellcome & Co. (U.S.A.) Inc., Tuckahoe, N. Y.		13
Caldwell & Bloor Co., The, Mansfield, O.		80
Camp, S. H., & Company, Jackson, Mich.		37
Central Pharmacal Company, The, Seymour, Ind.		41
Ciba Pharmaceutical Products, Inc., Summit, N. J.		23
Coca-Cola Company, The, Atlanta, Ga.		92
Columbus Hospital Supply Co., Columbus, Ohio		29-30
Columbus Pharmacal Co., The, Columbus, O.		93
Davies, Rose & Co., Limited, Boston, Mass.		71
Desitin Chemical Company, Providence, R. I.		6
Dietene Company, The, Minneapolis, Minn.		75
Eaton Laboratories, Norwich, N. Y.		16
Elder, Paul B., Company, Bryan, Ohio		54
Fischer, H. G. & Co., Franklin Park, Ill.		77
Fleet, C. B., Company, Inc., Lynchburg, Va.		28
Flint, Eaton & Company, Decatur, Ill.		87
Fougera, E., & Co., Inc., New York, N. Y.		88
Freeman Manufacturing Co., Sturgis, Mich.		76
Gallagher-Roach & Company, Columbus, O.		40
General Electric Company, X-Ray Department, Milwaukee, Wis.		60-61
General Foods Corporation, White Plains, N. Y.		56-57
Heinz, H. J., Company, Pittsburgh, Pa.		85
Holland-Rantos Co., Inc., New York, N. Y.		82
Hutton, W. E., & Company, Cincinnati, Ohio		58
Jenkins Laboratories, Inc., Auburn, N. Y.		24
Johnson & Johnson, New Brunswick, N. J.		96
Kremers-Urban Co., Milwaukee, Wis.		11
Lederle Laboratories Division, American Cyanamid Co., Pearl River, N. Y.		62
Liebel-Flarsheim Co., The, Cincinnati, O.		66
Lilly, Eli, and Company, Indianapolis, Ind.		101
Lippincott, J. B. Company, Philadelphia, Pa.		7
Lloyd Bros., Inc., Cincinnati, Ohio		64
Lloyd, Dabney & Westerfield, Inc., Cincinnati, Ohio		86
Loma Linda Food Company, Arlington, Cal.		63
Maico Company, Inc., Columbus, Ohio		43
Massengill, S. E., Co., Bristol, Tenn.		9
Mead Johnson & Company, Evansville, Ind.		22
Medco Products Co., Tulsa, Okla.		53
Medical Protective Company, The, Fort Wayne, Ind.		25
Merck Sharp & Dohme, Div. of Merck & Co., Inc., Philadelphia, Pa.		21
Merrell, Wm. S., Co., The, Cincinnati, Ohio		99
Milex-Alpha Products, Evanston, Ill.		52
Miller Surgical Company, Chicago, Ill.		32
Mueller, V., & Co., Chicago, Ill.		51
Mutual Benefit Life Insurance Company, Toledo, Ohio		42
Nepera Laboratories Division, Yonkers, N. Y.		78
Ohio Medical Indemnity, Inc., Columbus, O.		89-90
Organon, Inc., Orange, N. J.		79
Ortho Pharmaceutical Corp., Raritan, N. J.		27
Parke, Davis & Company, Detroit, Mich.		83
Pfizer Laboratories, Brooklyn, N. Y.		70
Picker X-Ray Corp., White Plains, N. Y.		74
Purdue Frederick Co., The, New York, N. Y.		73
Riker Laboratories, Inc., Los Angeles, Cal.		59
Robins, A. H., Company, Inc., Richmond, Va.		72
Roerig, J. B., and Company, Chicago, Ill.		26
Ross Laboratories, Columbus, Ohio		19
Sanborn Company, Waltham, Mass.		20
Sandoz Pharmaceuticals, Hanover, N. J.		15
Saunders, W. B., Company, Philadelphia, Pa.		10
Schering Corporation, Bloomfield, N. J.		68
Schmid, Julius, Inc., New York, N. Y.		33
Searle, G. D., & Co., Chicago, Ill.		1
Smith, Carroll Dunham Pharmacal Company, New Brunswick, N. J.		67
Smith, Kline & French Laboratories, Philadelphia, Pa.		2
Squibb, E. R., & Sons, Division of Olin Mathieson, Chemical Corp., New York, N. Y.		14
Testagar & Co., Inc., Detroit, Mich.		3
Turner & Shepard, Inc., Columbus, Ohio		98
Tutag, S. J., & Co., Detroit, Mich.		97
Upjohn Company, The, Kalamazoo, Mich.		34
U. S. Vitamin Corporation, New York, N.Y.		8
Wallace Laboratories, New Brunswick, N. J.		100
Warner-Chilcott Laboratories, Morris Plains, N. J.		17
Wendt-Bristol Co., Columbus, Ohio		4- 5
Westinghouse Electric Corporation, X-Ray Division, Baltimore, Md.		12
Winthrop Laboratories, Inc., New York, N. Y.		55
Wocher, Max & Son Co., The, Cincinnati, Ohio		36

Proposed By-Laws Amendments . . .

Proposals Sponsored by The Council for Action by House of Delegates Offered in Effort to Clarify Qualifications for Local Membership

PROPOSED amendments to the By-Laws of the Ohio State Medical Association will be presented to the House of Delegates for action at the 1957 Annual Meeting, Columbus, May 14-16. The proposed amendments are sponsored by The Council in an effort to clarify Chapter Eleven relating to the qualifications for membership in a component medical society. The proposals also rearrange certain existing provisions of Chapter Eleven for the sake of continuity and emphasis.

Following is the text of the existing Section 1 of Chapter Eleven and Section 1 as it will read if amended; also the text of a new Section 6 of Chapter Eleven, which consists of material now appearing in old Section 1.

EXISTING PROVISIONS

Section 1. Membership Qualifications. Each component society shall judge of the qualifications of its members. Every reputable physician who does not practice or profess to practice sectarian medicine, who is a bona fide resident of the county, and who possesses the qualifications enumerated in Chapter 1 of these By-Laws may be considered eligible for election to membership.

A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation. Original charges against a member may be heard by the Council in the same manner as provided in these By-Laws for disciplinary action by component societies. The Council of the Ohio State Medical Association shall have final authority to expel a member should a component society fail to do so after being so requested by the Council.

Where it is more convenient for a member to attend the meetings of the component society in an adjoining county, upon approval of the society in the county of his residence, his membership may be transferred and accredited to said adjoining component society.

PROPOSED AMENDMENTS

BE IT RESOLVED THAT Section 1 of Chapter 11 of the By-Laws be amended to read as follows:

Section 1. Qualifications for Members in a Component Society: To be eligible for any class of membership in a component society, a physician must possess the qualifications enumerated in Section 4 of Chapter 1 hereof and he must not be engaged, or profess to be engaged, in the practice of sectarian medicine.

To be eligible for active or associate membership in a component society a physician must be a bona fide resident of, or must conduct the major portion of his practice in, the county in which such component society is located; provided, however, that where it is more convenient for a member of a component society to attend the meetings of another component society located in a county adjoining that in which he holds his membership, such member, upon application to, and approval by, both the society in which he holds membership and the society in such adjoining county, shall be entitled to a transfer of his membership to such adjoining component society.

Subject to the provisions of the foregoing paragraphs of this Section 1, each component society shall be the sole judge of the qualifications necessary for any and all classes of membership in such society.

* * *

Be It Further Resolved that Chapter 11 of the By-Laws be amended by adding thereto the following sections:

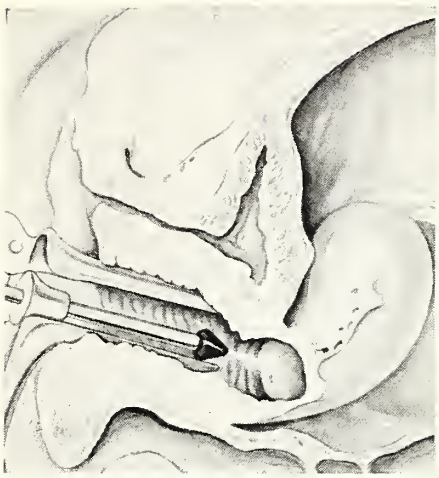
Section 6. Disciplinary Action by the Council of the Ohio State Medical Association. Original charges against a member of a component society may be instituted and be heard by The Council of the Ohio State Medical Association in the same manner as provided in Section 4 of this Chapter 11 for disciplinary procedure by a component society; and in any case in which a component society fails to take prompt disciplinary action against one of its members after being requested in writing by the Council of the Ohio State Medical Association to do so, the Council shall proceed to institute and prosecute such disciplinary action and to enter such order of dismissal or censure, or of suspension or expulsion from the component society, as the evidence adduced at the hearing may warrant.

Section 7. Effect of Revocation of License. A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation.

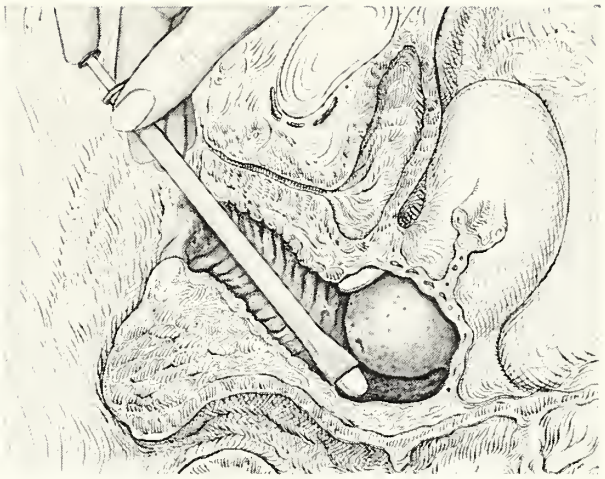
* * *

Be It Further Resolved that existing Section 1 of Chapter 11 be and the same hereby is repealed.

COMPREHENSIVE VAGINITIS REGIMEN



Powder Insufflation



Tablet Insertion

Floraquin® Rebuilds the Defense Mechanism in Vaginitis

Combined office and home treatment with Floraquin provides a comprehensive regimen which encourages restoration of the normal "acid barrier" to pathogenic infection.

Vaginal secretions normally show a high degree of protective acidity (pH 3.8 to 4.4). When this "acid barrier" is disturbed, growth of benign Döderlein bacilli is inhibited and that of pathogens encouraged. Floraquin not only provides an effective protozoacide and fungicide (Diodoquin®) destructive to pathogenic trichomonads and yeast, but also furnishes sugar and boric acid for reestablishment of the normal vaginal acidity and regrowth of the normal protective flora.

Suggested Office Floraquin Insufflation

". . . the vagina is treated daily by swabbing with green soap and water, drying and insufflation of Floraquin powder."*

Suggested Home Floraquin Treatment

"The patient is also issued a prescription for Floraquin vaginal suppositories which she is instructed to insert high into the vagina each evening. On the morning following each application of these suppositories, the patient should take a vinegar water douche. . . ."*

A Floraquin applicator is supplied with each box of 50 Floraquin tablets. G.D. Searle & Co., Chicago 80, Illinois, Research in the Service of Medicine.

*Williamson, P.: Trichomonad Infestation, M. Times *84*:929 (Sept.) 1956.

SEARLE

Resolution For OSMA Meeting

The Wood County Medical Society has advised that it approved the following resolution on March 14 and instructed its official delegate to present the resolution to the House of Delegates of the Ohio State Medical Association at the 1957 Annual Meeting of the Association, May 14-16, Columbus:

Whereas, we the members of the Ottawa County Medical Society, have become acutely aware of the inroads toward socialism that are being made by the enemies of free enterprise and the advocates of central nationalization and the welfare state, and

Whereas, we do believe that our present form of free, private enterprise is responsible for our status in world leadership, not only in medicine but also the fields of economics, labor, management, freedom of speech, religious tolerance, and many others, and

Whereas, we observe that in other lands where these freedoms have succumbed to the Pollyanna promises of left-wing elements, government has deteriorated; self-confidence has been destroyed; self-respect has no rewards; and personal ambition has become old fashioned; and

Whereas, our organization sincerely hopes and prays that no further freedom will be given up by default and our typical American naivete in conceding or giving up our rights gradually,

Be it resolved, that we manifestly proclaim our support of the American traditions of Constitutional government; of proper delegation of rights to the Sovereign States and local communities; of free and private enterprise; of federal abstention from control of education, management, labor, religion, and the professions; and that we abhor and will oppose the evil influence of those visionaries and groups who would attempt to mislead us down the road of creeping socialism toward an unattainable Utopia but eventual disillusion.

Dr Homer Smith To Speak for Phi Delta Epsilon

Upsilon Chapter of Phi Delta Epsilon Fraternity, at Western Reserve University School of Medicine, will present its 11th annual National Lectureship on April 26, at the Allen Memorial Library Auditorium, Cleveland, at 8:00 p. m. The speaker will be Dr. Homer Smith, professor of physiology at New York University School of Medicine. His subject will be "De Urina," a sequel to his well known lecture, "From Fish to Philospher."

Educational Film for Diabetics

"Urine Sugar Analysis for Diabetics," a film made as a visual aid to be used in the education of diabetic patients, is available to medical and allied professional groups from Ames Company, Inc., Elkhart, Ind. The 16 mm. color, sound film runs approximately 10 minutes.

Aid for the Aged Adopts New Radiation Therapy Schedule

A revised schedule of fees applying to radiation therapy has been adopted by the Division of Aid for the Aged, on recommendation of its medical advisory committee. These will apply to radiation therapy received by those eligible to medical care under the Division's medical program. The schedule which is as follows is an addition to the Medical and Surgical Fee Schedule which became effective on July 1, 1956, and which was published in the August, 1956, issue of *The Journal*:

RADIATION THERAPY

1. Superficial (low voltage) X-ray and External Radium and Cobalt-60 Therapy:
   - a. Benign lesions ..... not to exceed $25.00
   - b. Malignancies ..... not to exceed $35.00
   - c. Large skin lesions requiring multiple applications, or specially difficult cases—fee to be adjusted.
2. Deep (high voltage) X-ray Therapy
   Class I: Radical treatment for malignancy, 3 to 5 weeks therapy:
   Per treatment ..... $ 7.50
   Maximum fee $150.00
   Class II: Palliative or minor treatment for malignancy, 2 to 3 weeks therapy:
   Per treatment ..... $ 7.50
   Maximum fee ..... $ 90.00
   Class III: Incidental treatments, e. g., lymphomas or benign conditions requiring deep x-ray therapy:
   Per treatment ..... $ 7.50
   Maximum fee ..... $ 75.00
3. Interstitial or intracavitary implanation of radium or cobalt-60. Total fee not to exceed $75.00.
4. Radioactive Isotope Therapy:
   - a. Iodine-131 for thyrotoxicosis, not to exceed ..... $ 75.00
     Repeat in one year, not to exceed $ 50.00
   - b. Iodine-131 for ablation of thyroid, not to exceed $100.00
   - c. Iodine-131 for thyroid cancer, not to exceed $150.00
   - d. Phosphorus-32 for polycythemia or leukemia, ... $ 25.00 per treatment visit. Maximum—three treatments in any six months period.

Porterfield Named to High Rank

Dr. John D. Porterfield, formerly director of health and director of mental hygiene and correction for the State of Ohio, who has been serving as assistant to the surgeon general, U. S. Public Health Service, has been appointed assistant surgeon general, equivalent to the rank of brigadier general.



Wonderfully Simple. . .

Simply Wonderful!

Baker's Modified Milk is a complete infant food, easy to prescribe and prepare in hospital and home.

Available in liquid and powder forms, both are made *exclusively* from Grade A Milk (U.S.P.H.S. Milk Code). Both contain all requirements for *complete* infant nutrition.

Baker's Liquid — generally preferred for its greater ease of preparation.

Baker's Powder — particularly adaptable for feeding prematures and for use as complemental and supplemental feedings.

Both forms are extremely low in price, costing less than a penny per ounce of formula.

Furnished to hospitals without charge, of course.

Feeding Directions

BAKER'S MODIFIED MILK (Liquid)

NEWBORN INFANTS (Hospital)—1 part Baker's to 2 parts cool water.

FIRST WEEK AT HOME — 1 part Baker's to 1½ parts cool water.

AFTER FIRST WEEK AT HOME — 1 part Baker's to 1 part cool water.



Liquid Powder

BAKER'S MODIFIED MILK

THE BAKER LABORATORIES, INC.

Milk Products Exclusively for the Medical Profession

***Main Office:* Cleveland 3, Ohio • *Plant:* East Troy, Wisconsin**

Ohio Legislature . . .

Session in Full Swing: Many Medical-Health Bills in the Hoppers: Council Sets Policy on Many of Them at Meeting in Columbus. Feb. 23

THERE are 1,374 bills in the hoppers of the Ohio General Session. Many of them are on medical-health subjects. Meeting in Columbus on February 23, The Council reviewed many of the medical-health bills. It set policy on a large number. Some were held for further study.

Some of the measures introduced on March 4 and 5—the 5th being the deadline for introduction of bills—have not as yet been analyzed by officials of the OSMA. After they have been studied, official statements of policy will be adopted to guide the County Medical Societies and representatives of the OSMA.

Bulletins setting forth the official policies on medical-health bills reviewed to date have been sent to County Medical Society officials and legislative chairmen. It is their responsibility to discuss proposals with their respective representatives and senators. Following are bills reviewed to date and the action of The Council on them:

H. B. 5 and S. B. 369: To create a separate licensing board for chiropractors. **Active Opposition.**

H. B. 809 (Connors): Would compel Ohio to recognize naturopathy and to provide for examination and licensing of naturopaths by State Medical Board. **Active Opposition.**

S. B. 243: To create a separate board to examine and license masseurs, now licensed under Medical Practice Act by Medical Board. **Active Opposition.**

H. B. 134 and H. B. 667: To revise the Food and Drug law. **Approved in principle, providing proposal gives Department of Health proper administrative responsibilities.**

H. B. 384: To provide for more dogs for medical research and medical teaching. **Active Support.**

H. B. 930 (Corkwell): To provide for licensing of rest homes by State Department of Health. **Approved.**

S. B. 360 (Gray): Increase from one-third to two-thirds of grain the amount of dihydrocodeinone which may be dispensed or administered in 48-hour period without the keeping of a record. **Approved.**

H. B. 574 and H. B. 642 (Jones): Concerns consolidation or merger of health districts within a county. **Endorsed in principle.**

H. B. 56: To increase penalties for practicing medicine without a license and add injunction to penalties. **Active Support.**

H. B. 140: To permit private insurance carriers to write Workmen's Compensation Insurance in competition with the State Fund. **Endorsed in principle.**

S. B. 101: To create a state board to license and regulate medical technicians. **Appears to be no need for such board.**

H. B. 802 (Jump): Would make the county the local relief area, eliminating city relief areas. **Endorsed in principle.**

H. B. 13: To raise the per diem allowance of Board of Health members from $3.00 to $6.00. **Approved.**

S. B. 178: To establish a state board to examine and license dispensing opticians. **Appears to be no need for such board.**

S. B. 212: To establish a temporary disability compensation program in Ohio as part of the Unemployment Compensation system, under which lost-time compensation and medical-hospital costs would be paid to those unable to work because of off-the-job illness or injury. **Active Opposition.**

H. B. 409: To create a three-member state board of hospitalization appointed by the Governor to safeguard public interest in hospitalization service associations. **Appears to be no need for such board.**

H. B. 425: Requires detailed report of organization of hospitals and charges for medical services, salaries, etc., in order to be eligible for per diem disbursements to hospitals for indigent motor vehicle injury cases. **Needs further study.**

S. B. 108: To increase cost of certified copy of birth certificate from 50 cents to $1.50. **No Objection.**

S. B. 73: To permit Ohio to enter into compacts with other states for care of the mentally ill. **No Objection.**

H. B. 64: To empower Boards of Trustees of County Hospitals to hire counsel to bring legal action to collect delinquent accounts. **No objection.**

S. B. 65: To add state aid to the needy chronically ill to present public assistance programs for the aged, blind, dependent children, etc. **No action; needs more study.**

H. B. 53: To make group life insurance avail-

able to lawyers, physicians, dentists, etc., through their professional or trade associations. **Approved.**

H. B. 118: To permit issuance of marriage licenses to epileptics under certain conditions. **Needs further study.**

S. B. 205: Permits issuance of six-month restrictive driver's license to epileptics. **Needs further study.**

H. B. 370: Enabling act for the establishment of non-profit dental care corporations. **No Objection.**

S. B. 140: To create a Division of Alcoholism in the Department of Mental Hygiene. **Endorsed.**

S. J. R. 18: Asking Legislative Service Commission to conduct study of mental health and child guidance clinics and the present program for distribution of tranquilizer drugs carried on by the Department of Mental Hygiene. **Needs further study.**

H. B. 294: To regulate use of fluoroscopes for non-medical purposes. **Endorsed in principle.**

H. B. 281: Authorizes Director of Health to advise and assist communities in combatting air pollution. **Endorsed in principle.**

S. B. 152: Makes disability from exposure to radio-active materials compensable under Workmen's Compensation Act. **Endorsed in principle.**

H. B. 322: Makes Ohio Department of Health responsible for establishing and maintaining minimum standards for city and county benevolent institutions in addition to present responsibility for establishing and maintaining standards for voluntary and governmental hospitals. **Needs further study.**

H. B. 328: To remove the requirement that one of the three-member Cosmetology Board shall be a physician. **Opposed.**

S. B. 199: Specifies that one member of the Ohio Public Health Council shall be a dentist. **No Objection.**

S. B. 200: Provides that Superintendent of each State Mental Hospital may appoint an advisory council of 5 to 11 members. **Needs further study.**

New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since February 1, 1957. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

BUTLER COUNTY
Denis F. Cash, Hamilton
Ernest B. Cunningham, Middletown
Melvin N. Davis, Hamilton
Archer B. Parham, Jr., Hamilton
William Polanka, Hamilton
Paul E. Smalley, Oxford

CHAMPAIGN COUNTY
Theodore E. Richards, Urbana

CLARK COUNTY
Samuel S. Leber, Springfield
E. Sue Miller, Springfield

CUYAHOGA COUNTY
Marie S. A. Carle, Mayview, Pennsylvania
Nicholas Demmy, Cleveland
Curtis F. Deters, Cleveland
Robert L. Prouty, Cleveland
Elmer M. Wright, Cleveland

ERIE COUNTY
Jane W. Kienle, Sandusky

GALLIA COUNTY
Walter Ulbrich, Canton

GREENE COUNTY
John D. Tharp, Xenia

HAMILTON COUNTY
Albert H. DeGarmo, Cincinnati
Frank G. Farley, Cincinnati
James E. Hetherington, Cincinnati
John W. McConnell, Cincinnati
Paul V. D. Newland, Cincinnati
William J. O'Rourke, Cincinnati
Manuel M. Rodarte, Cincinnati
Brigitte R. Rosenberg, Cincinnati
Philip H. Rosenberg, Cincinnati
Sherwin, S. Zeid, Cincinnati

JEFFERSON COUNTY
Ralph M. Rea, Mingo Junction
Paul W. Ruksha, Steubenville

LORAIN COUNTY
Peter J. Ferrato, Lorain

LUCAS COUNTY
Richard F. Baer, Toledo
William J. Meyer, Toledo

MAHONING COUNTY
Michael I. Szauter, Youngstown

MARION COUNTY
Angus M. Cameron, Marion
Paul E. Lyon, Marion

MIAMI COUNTY
Harry R. Hittner, West Milton
Edmund I. Saunders, Covington

PAULDING COUNTY
John H. Schaefer, Paulding

PORTAGE COUNTY
Allen R. Evans, Ravenna

SANDUSKY COUNTY
Kathryn P. Noble, Fremont

SUMMIT COUNTY
Lauren M. Brown, Akron
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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

CINCINNATI CENTENNIAL IS MEDICAL MILESTONE

The eminently successful Cincinnati Academy of Medicine centennial celebration February 27 to March 5 proved to be a fitting observance of the Academy's 100th birthday.

Planning and carrying out the ambitious program—from the Health Fair to the outstanding speakers for the centennial convocations—involved thousands of man hours of work by the Academy's members. Further, the 100 years of medicine in Cincinnati have been recorded for future generations through "The Cincinnati Doctors' Forum," a volume of nearly 400 historical pages written especially for the centennial by a professional historian, thanks to the efforts of Academy members.

The scope of the Health Fair, open to the public daily and attended by thousands of adults and school children, was such that it filled the sprawling Cincinnati Music Hall. The convocation speakers, Dr. Walter C. Alvarez of the Mayo Clinic, Dr. Paul Dudley White and the University of Edinburgh Nobel prize-winner, Sir Edward Victor Appleton, all are outstanding personages.

The importance the citizens of Cincinnati have attached to the Academy of Medicine is reflected by a single word in a congratulatory editorial in the February 27 edition of the *Cincinnati Times-Star*. That word is "our." The editorial noted that "* * * our Academy of Medicine is celebrating its centennial * * *." It did not say "the Academy" or "the doctor's Academy" but "our Academy." In our opinion, the use of that one word in the editorial strongly indicates the acceptance of the traditions and programs of the Academy of Medicine as an important segment in the life of the people of Cincinnati.

SUPPORT URGED FOR NEW SECTION ON INDUSTRIAL MEDICINE

The newly created Section on Industrial Medicine of the Ohio State Medical Association will make its debut at the 1957 Annual Meeting of the association in Columbus.

The meeting of the section will be on Tuesday morning, May 14, starting at 9:30 o'clock. An excellent program has been arranged, details of which will be found in the meeting program published in this issue of *The Journal*.

This section should receive the enthusiastic support of a wide cross section of physicians. The practice of industrial medicine has become an important part of medicine. Through this section, the OSMA will attempt to give interested members up-to-date refresher work; also attempt to interest more members into taking more interest in this phase of practice. Even the man who is exposed to industrial practice only occasionally will find the programs presented by the section of interest and importance.

Here's hoping the membership will get this newest section off to a flying start on Tuesday, May 14.

SOME GOOD HUNCHES FOR THE MEDICAL WITNESS

For the medical witness—particularly the general practitioner—who is filled with trepidation when facing appearance in court, a list of "do's and don'ts" has been compiled by the *Medical Annals of the District of Columbia*.

The publication advises the physician to familiarize himself with the case thoroughly and to have a pre-trial consultation with the patient's attorney.

It also advises that to be a good medical witness:

1. Tell the truth.
2. Come prepared.
3. Don't be afraid, but be modest and natural in actions and speech.
4. Listen to questions, and answer only what is asked.
5. Admit if you don't know. Don't hedge or become flustered.

The article also suggests that the doctor who feels the patient has no legitimate case should convey his feelings to the patient's attorney and remove himself from the case.

FEW WORDS MAY FORESTALL MALPRACTICE LITIGATION

A perusal of briefs of several malpractice suits in which the court found against the physician reveals in those cases an important omission on the part of the doctors:

They failed to inform fully their patients as to the nature and extent of the therapy. The fact that the plaintiffs in these suits could contend that they were not fully informed was damaging to the defendants.

It would appear that too often physicians assume that the patients are fully understanding of the type and extent of their treatment, whether it be surgical or medical. Such assumptions have, in malpractice suits, proved to be costly.

A good preventive of such situations is to explain fully to the patient—and do it in lay

terms—just what is being done. As a further safeguard in cases that apply, it would be well to explain that conditions may be found that dictate additional therapy in the best interests of the patient.

MEDICOLEGAL ASPECTS OF BLOOD TRANSFUSIONS

Physicians who have anything to do with blood transfusion programs should read—it's a must—the article on the medicolegal aspects of these programs which appeared in the January 26 issue of *The Journal of the AMA* under the sponsorship of the AMA Legal Department.

One point stressed is that medical techniques must be perfected and every possible means used to avoid medical errors in these procedures as the legal problems will not be eliminated or minimized unless the medical profession points the way and takes steps to abolish the causes of the legal actions.

The article is quite comprehensive. It is well documented. The warning signals which it flashes and the recommendations made for preventing errors should be of extreme value to all physicians but especially to those who are directly concerned in managing transfusion and blood donor programs or are in a position to pass on pertinent information to their colleagues in practice or to those still in training.

What To Write For

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

What Should I Do? This booklet on accidents involving children has three purposes: To present the importance of the child accident problem, to arouse interest in child accident prevention, and to suggest what to do until medical aid is obtained. Good outline for addresses before lay groups. Write OSMA, 79 E. State Street, Columbus 15, Ohio.

* * *

What Will New Industry Mean to My Town? Summary of two case studies on impact of new industry on small towns. Booklet is designed to provide general indication of what may be expected of industrialization of a small community. (15 cents) Write Superintendent of Documents, Government Printing Office, Washington 25, D. C.

* * *

Guides to Action on Chronic Illness. Condensed report of facts and ideas brought to the 1956 National Health Forum. ($1) Write National Health Council, 1790 Broadway, New York 19.

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COURSE FOR GENERAL PRACTITIONERS

Four weeks intensive full time instruction covering those subjects which are of particular interest to the physician in general practice. Fundamentals of the various medical and surgical specialties designed as a practical review of established procedures and recent advances in medicine and surgery. Subjects related to general medicine are covered and the surgical departments participate in giving fundamental instruction in their specialties. Pathology and radiology are included. The class is expected to attend departmental and general conferences.

FOR INFORMATION ABOUT THESE AND OTHER COURSES ADDRESS—
THE DEAN, 345 West 50th Street, New York 19, N. Y.

Shortage of Polio Vaccine May Slow Up Immunizations

According to Surgeon General Burney of the USPHS, a new problem was developing in regard to Salk poliomyelitis vaccine as this issue of *The Journal* went to press March 20. Shortages were being reported from some localities. To remedy what was regarded as a temporary situation, Dr. Burney and the American Medical Association recommended that each community make a survey of its available supplies before launching new or stepped-up immunization programs.

Dr. Ralph E. Dwork, director of the Ohio Department of Health, emphasized the same precaution and urged that stress be put upon priority for immunizing the under 20 age group and pregnant women as long as there is shortage in any community.

In a statement Dr. Burney says: "It is apparent that the public is responding in substantially increasing numbers to the appeals of the American Medical Association, the National Foundation for Infantile Paralysis, the Public Health Service and other groups to be vaccinated. We are pleased that available supplies are being used more rapidly."

While the present supply situation exists, Dr. Burney recommended three steps to obtain most effective use of the vaccine:

First, if supplies are limited, give preference to immunization of those under age 20 and pregnant women.

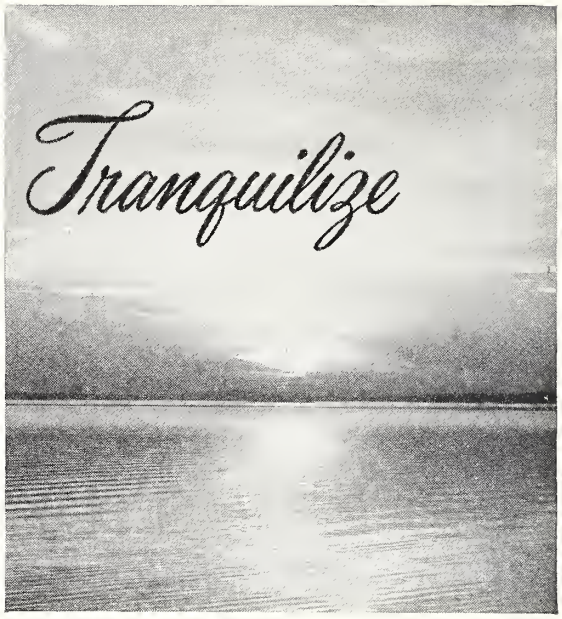
Second, local communities should begin their programs with first injections as supplies become available, without waiting to accumulate sufficient reserves to complete second and third injections.

Third, if planning groups would stagger the dates of community vaccination drives, particularly in large cities, that also would help to even out available supplies.

Dr. Burney said he had written the manufacturers calling their attention to the increase in demand and urging that they do everything possible to increase production.

In Ohio the future supply of Federal-grant vaccine seemed limited. As of mid-March the Ohio Department of Health had 63,000 cc. of vaccine in process of being delivered to local health departments. There was another 180,000 cc. on order, but delivery of the full amount was not promised until mid-April. After that supply is used, Ohio has Federal-grant money enough to purchase an additional 115,000 cc.

Unofficial reports indicated that there were some shortages of vaccine in certain areas of Ohio's commercial supply houses. Supply through these channels obviously will depend upon rate of production in the five national manufacturers which are producing Salk vaccine.



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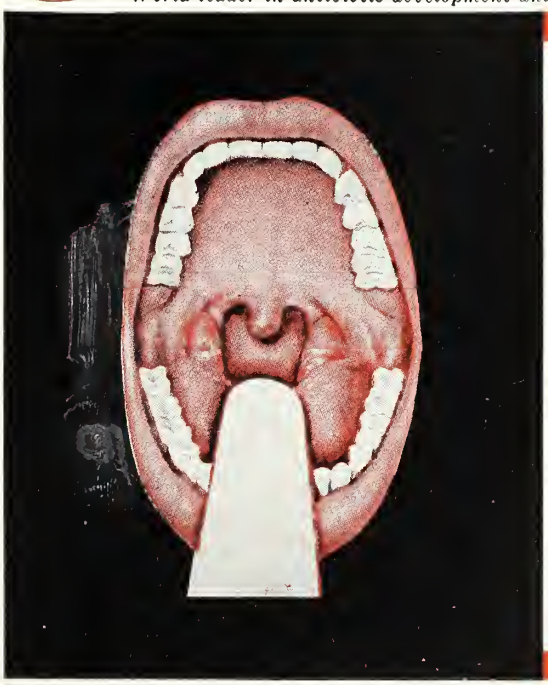
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and "... often useful in the treatment of infections due to staphylococci resistant to one or several of the regularly used antibiotics"

"side effects . . . [are] notable by their absence"[1]

1. Carter, C. H., and Maley, M. C.: Antibiotics Annual 1956-1957. New York, Medical Encyclopedia, Inc., 1957, p. 51.

Antibiotics For Prevention of Recurring Rheumatic Fever Attacks Are Available

The Ohio Department of Health is making available to practicing physicians on request, through their local health departments, antibiotics for prevention of recurring attacks of rheumatic fever.

The program resulted from a recommendation of the 1956 Ohio Health Commissioners' Conference. Its three objectives are (1) to prevent recurrence of rheumatic fever and accompanying heart damage by means of a long-term prophylaxis program, (2) to establish a heart program to be carried out cooperatively by the physician, local and state health departments, and (3) to stimulate reporting of rheumatic fever in Ohio to obtain information for evaluation and further program planning.

Antibiotics provided under the program include: (1) Benzathine Penicillin G (injectable) in 600,000 unit or 1,200,000 unit disposable syringes. (2) Penicillin G (oral penicillin) 200,000 unit; 250,000 unit tablets. (3) Penicillin V, 400,000 unit capsules.

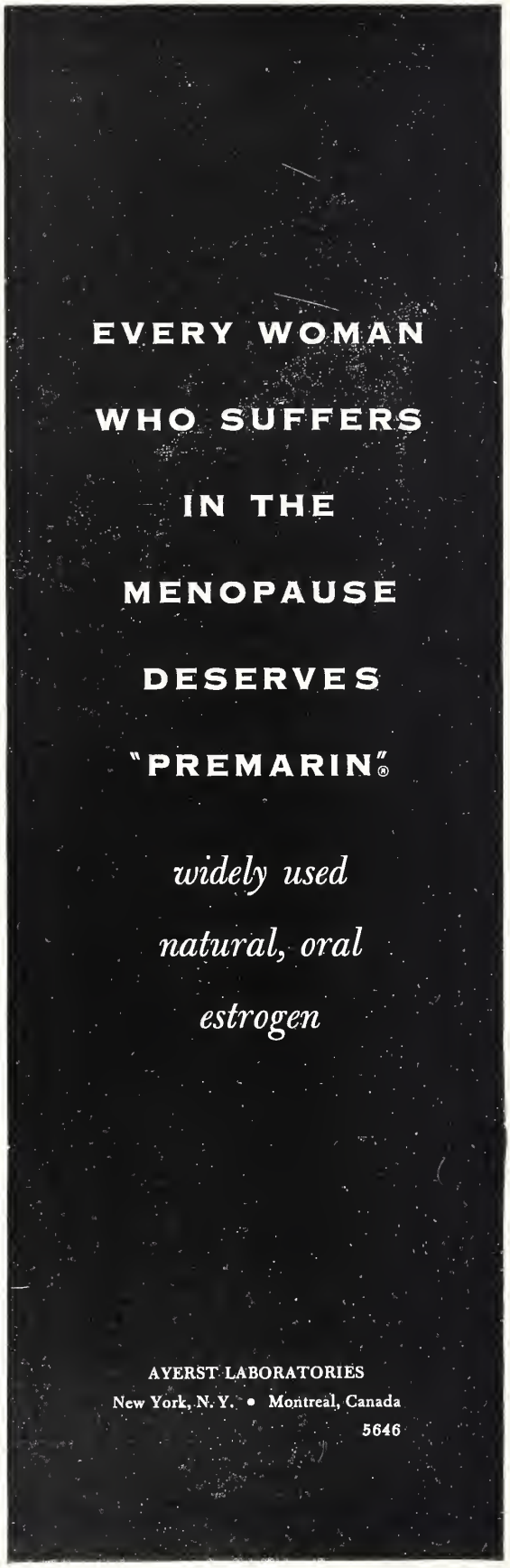
An attending physician may request the drugs for prevention of recurrence in any previously diagnosed case of rheumatic fever. There will be no charge for the drugs, to either the physician or the patient, but the physician may make a charge to the patient for administering the drug, if he desires.

The State Health Department also will provide a small reserve supply of drugs to be kept at local health departments for use in prevention of sub-acute bacterial endocarditis. This is to provide a supply to a physician or dentist whose rheumatic fever patients are undergoing delivery or general surgery, or oral surgery or dental manipulations.

Two forms have been prepared for requisition of the drugs. The first is "Rheumatic Fever Prophylaxis Program Enrollment Application—ODH-RF-1." The second form is "Reorder for Rheumatic Fever Prophylaxis Antibiotics ODH-RF-2." The forms are obtainable at local health departments.

The attending physician is to fill out and sign the "Enrollment Application" and forward it to his local health commissioner, who will sign and duplicate the order, then forward it to the Ohio Department of Health, Division of Chronic Diseases. This will serve as the initial order for patients for whom the drugs are requested. The "Reorder" form will be processed in the same manner. After the initial reorder, the physician may obtain additional drugs simply by contacting his local health department.

Local health departments have been advised



to confer with local medical societies to work out details for administering the program.

The American Heart Association's Committee on Prevention of Rheumatic Diseases has recommended primary prevention of streptococcal infections by prolonged antibiotic prophylaxis.

Increase Noted in Year's Payments from Hospital and Medical Insurance

Hospital and medical care payments, to help cover the cost of treatment and physicians' services, amounted to $2.1 billion in 1956, the Health Insurance Institute reported. This figure, the Institute stated, includes replacement of income lost through sickness or disability. A survey conducted among the country's insurance companies revealed that reimbursements through group insurance plans in force during the year totaled $1.5 billion, or 20.9 per cent over 1955, while payments through individual policies totaled $601 million, a gain of 12.8 per cent, for an overall increase of 18.5 per cent in benefit payments over 1955.

Payments to policyholders covered under hospital expense insurance, for in-hospital services, amounted to over $855 million, the Institute further reported, with $629 million paid under group policies and $226 million paid by insurance companies to individual policyholders.

Reimbursements to help cover the cost of surgeons' fees amounted to $346 million, with $273 million received by holders of policies under group plans, and $73 million going to persons covered by individual insurance policies.

A total of $58 million was paid to persons under medical expense contracts, for non-surgical medical care and treatment, $47 million through group policies, and $11 million to individual policyholders.

Benefit payments to those protected against the cost of serious, or catastrophic illness or accident through major medical expense insurance, including supplemental and non-supplemental coverage to the basic health cost plans, amounted to over $65 million. Group plan payments totaled $62 million, while individual contract benefits were more than $3 million. A further breakdown of the payments made for services covered by *major medical expense insurance* is as follows:

Hospital expense	$31,641,000
Surgical expense	18,483,000
Medical expense	7,694,000
Nurse	4,185,000
Drugs	1,214,000
Other	1,214,000

In concluding its report of payment for health care by the insurance companies throughout the United States, the Institute stated that the increase in such payments reflects the continued efforts of the public to pay its doctor and hospital bills through the voluntary non-governmental mechanism.

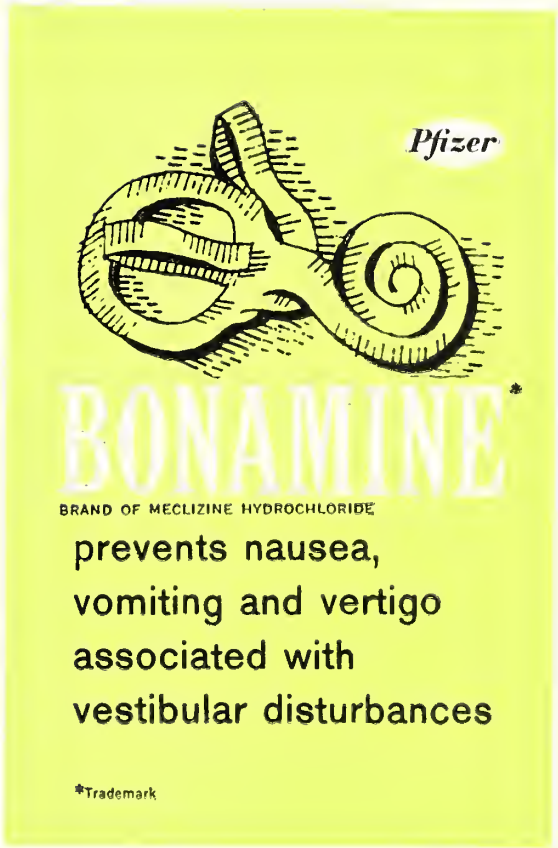
Columbus Cancer Survey Progressing Well

The cervical cancer survey being conducted in Columbus under sponsorship of the U. S. Public Health Services is making excellent progress, according to a report in a recent issue of the *OSU Health Center Journal*. Columbus was selected last year as one of five cities in the United States where the 3-year survey among women over 20 would be made.

During the first five months of the survey, 15,638 women were checked, 60 per cent in private physicians' offices. The rest were checked at the Cancer Survey Clinic on the campus and other clinics established in Columbus hospitals and at the Columbus Health Center.

Unsatisfactory smears were found in 469 of the cases checked with 164 considered suspicious. Of these 164, there were 26 women who were confirmed to have cancer. They had all been treated and the remaining patients were under study when the report was made.

Examinations are voluntary and consist of taking a smear which is sent to the Department of Pathology at OSU and examined. If suspicious cells are found the woman is referred to her physician or the Department of Obstetrics and Gynecology for further tests and treatment.



Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

Congressmen are receiving form postcards urging an investigation of the Food and Drug Administration for attempting to stop Hoxsey cancer treatment. FDA twice has succeeded in Federal Court actions against the Hoxsey treatment, yet the treatment still is being promoted. The form postcard urges "investigation of the Food and Drug Administration to correct abuses and restrain this branch of Government from trying to destroy the Hoxsey treatment for cancer."

* * *

Veterans Administration, National Research Council and National Institute of Neurological Diseases and Blindness are joining in research in multiple sclerosis. Objective is to learn if any role is played in development of the disease by geographic, climatic and allied environmental factors.

* * *

VA has made M. H. Gordon, Ph. D., assistant director of central research laboratory for the nationwide evaluation of tranquilizing drugs in VA hospitals. He is a former clinical psychologist at the Chillicothe, Ohio, VA Hospital.

* * *

Federal Housing Administration is studying possibility of mortgage loan guarantees to nonprofit organizations, including hospitals, for construction of nursing homes. As contemplated, such a facility, to receive guarantee, would have to be built separate from the hospital and patients would have to be 60 years old or older as well as permanent residents of the home.

* * *

Government settled for $175,000, according to Justice Department, a record $210,000 malpractice suit involving the U. S. Ex-servicewoman won the court judgment for disability resulting from continuous caudal anesthesia administered in a West Coast naval hospital.

* * *

Annual Defense Department report on health and medical activities, submitted to Secretary Wilson, places emphasis on continued expansion of medical education for National Defense, establishment of joint committee on aviation and pathology, importance of role played by university faculty members in execution of nutrition surveys in Pakistan, Iran and Korea, and noted improvement in procurement and retention of medical officers.

Seven associations, including the AMA, have set up a national organization, "American Thrift Assembly for Ten Million Self-Employed," to promote legislation for establishment of voluntary pension plans for the self-employed. Objective of the organization is passage of this legislation, the Jenkins-Keogh proposal long supported by the AMA, to authorize deferment of income tax on a portion of income if put into a retirement or annuity program, with tax to be paid as the money is received back in the form of retirement benefits.

* * *

Food and Drug Administration has warned drug and pharmaceutical firms against indiscriminate distribution of physicians' drug samples, after noting "at several professional meetings potent prescription drugs were freely distributed to nonphysicians who happened to stop at the * * * exhibits."

* * *

In field of air pollution control, Public Health Service is emphasizing grants to institutions for easing shortage of courses and curricula available to potentially interested students.

* * *

Despite seasonal decline of new construction activity in February, private hospital and institutional construction was up three per cent over January and 36 per cent over February, 1956.

* * *

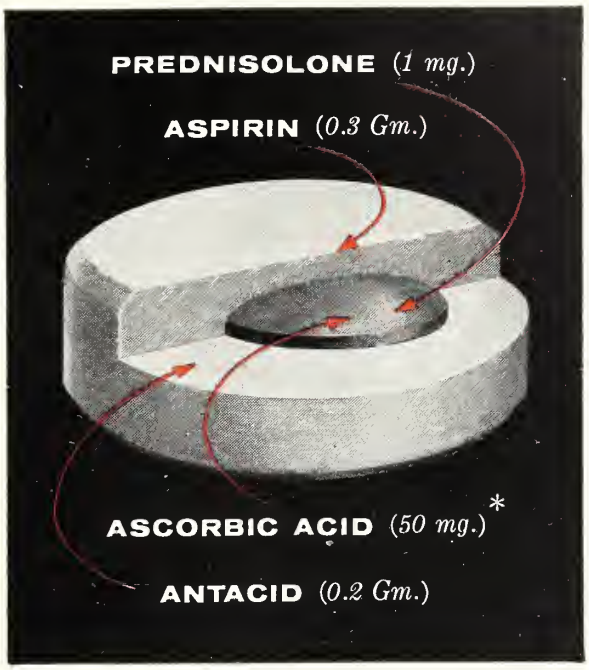
Joint Blood Council, with $50,000 Federal grant, has started nationwide survey of U. S. blood bank resources to obtain information for preparation of standards for blood bank accreditation, development of a glossary of terms, inventory of research in blood and blood derivatives, and assemblying and analysis of needed data.

* * *

Medical Advisory Committee on Old Age and Survivors Insurance reports misunderstandings over new OASI program for pensions to persons certified as disabled at age 50. One is that people do not realize disability standards are more severe than other Federal programs. The other is that some physicians misunderstand their role. They are asked only to describe the disability in sufficient detail in order that it be evaluated.

* * *

The service-connected loss of sizeable parts of both feet may entitle a veteran to a Government grant for a "wheel chair" home, although special shoes enable him to walk, Veterans Administration has ruled.



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In Memoriam . . .

Chester William Waggoner, M. D., Toledo, president of the Ohio State Medical Association, 1930-1931; an outstanding physician and leader in many phases of professional work, died on March 17, at the age of 73. A native of nearby Lindsey, Dr. Waggoner lived most of his life in Toledo where he graduated from Toledo Medical College in 1906. He later took graduate work at Harvard, Rush Medical College and Johns Hopkins University; was certified by the American Board of Internal Medicine, and served for a number of years as director of medicine at St. Vincent's Hospital. From 1916 to 1920 he served as Toledo health commissioner, and in 1936 he was appointed to the State Medical Board, a post he held for 21 years. Before serving successively as President-Elect, President and Past-President of the OSMA, Dr. Waggoner was on The Council as Councilor of the Fourth District. He served also for a number of years as Delegate to the American Medical Association. He had been honored by the Academy of Medicine of Toledo and Lucas County when he was presented the 50-Year Pin and Certificate of the State Association. In spite of his busy professional life, Dr. Waggoner found time to devote to his favorite hobbies, collecting first editions and fine paintings. He was a Fellow of the American College of Physicians, a member of several Masonic bodies, the Elks Lodge and the Inverness Club. His widow and two daughters survive.



C. W. WAGGONER, M. D.

Firm C. Burket, M. D., St. Petersburg, Fla.; Eclectic Medical College, Cincinnati, 1922; aged 66; died February 13; former member of the Ohio State Medical Association and the American Medical Association. A practicing physician for many years in Sandusky, Dr. Burket retired several years ago and moved to Florida. He is survived by a son. Dr. Robert L. Burket, Cincinnati, another son in Tennessee, a daughter in Florida and a brother.

J. Frank Diennen, M. D., St. Petersburg, Fla.; Indiana University School of Medicine, 1908; aged 72; died February 18; former member of the Ohio State Medical Association and the American Medical Association. A former Cleveland physician, Dr. Diennen was surgeon for the Erie, Nickel Plate and Chesapeake & Ohio Railroads. He retired in 1953. Survivors include his widow, two sisters and a brother.

Verne A. Dodd, M. D., Columbus; Ohio Medical University, Columbus, 1903; aged 76; died February 22; member of the Ohio State Medical Association, the American Medical Association and Fellow of the American College of Surgeons; past-president of the Columbus Academy of Medicine; recipient of the OSMA 50-Year Award. Dr. Dodd was recognized for his outstanding career as a surgeon and as an educator over a period of 45 years. He began his teaching career as an instructor in orthopedic surgery at Ohio Medical University in 1905. In 1921 he was made chairman of the Surgery Department at Ohio State and the next year was named to the positon of chief of staff at University Hospital. During World War I he served in both the Army and Navy. In 1917 he was made lieutenant commander in the Naval Reserve and later became captain. He gave up his administrative duties at the University in 1947 but continued to teach until 1951. In 1943 he was given the honorary Doctor of Laws degree by Ohio State. Dr. Dodd was a member of several Masonic bodies, Phi Rho Sigma, Alpha Omega Alpha and other organizations. Survivors include his widow, a son and a daughter.

Clarence W. Engler, M. D., Cleveland; Western Reserve University School of Medicine, 1919; age 61; died February 25; member of the Ohio State Medical Association and the American Medical Association. A practicing physician for many years in Cleveland, Dr. Engler was chief of the ear, nose and throat division at Charity and City Hospitals and assistant clinical professor of otolaryngology at Western Reserve. He was a member of the Union and Hermit Clubs and the Pasteur Club. A sister survives.

James D. Goodman, M. D., Elyria; Ohio State University College of Medicine, 1939; age 44; died February 14; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Ophthalmology. A native of Cleveland and practicing physician there for a number of years, Dr. Goodman for the past six years resided in Elyria. He was a member of the Cleveland Ophthalmological Society, the Elyria Chamber of Commerce and the Elyria B'nai Abraham Temple. Survivors include his widow, his mother, three brothers and two sisters.

Paul H. Hildebrant, M. D., Mt. Sterling; University of Michigan Homeopathic Medical School, 1912; age 79; died January 30; former member of the Ohio State Medical Association. Dr. Hildebrant had been a practicing physician for some 32 years in Mt. Sterling and had previously practiced in Washington C. H. He was active in community affairs and served a term as mayor of Mt.

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prednisolone and hydroxyzine



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Sterling. His church was the Congregational Christian. His widow and a brother, Dr. Hugh Hildebrant, of Fort Lauderdale, Fla., survive.

James J. Joelson, M. D., Cleveland; Columbia University College of Physicians and Surgeons, 1920; age 59; died February 8; member of the Ohio State Medical Association and the American Medical Association; member of the American Urological Association; Fellow of the American College of Surgeons; diplomate of the American Board of Urology. Dr. Joelson had been a practicing physician in Cleveland since 1924. During World War II he was in the Army Medical Corps where he attained the rank of lieutenant colonel. Affiliations included memberships in the Medical Arts Club, Alpha Omega Alpha and Sigma Xi. Survivors include his widow and four stepchildren.

Leo Lauter, M. D., Toledo; medical degree from Albertus University Faculty of Medicine, Konigsberg, Prussia, 1920; age 63; died February 11; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A practicing physician in Toledo, Dr. Lauter left Germany in 1936 during the Nazi regime. His widow, who is a physician, and three children survive.

John C. Littell, M. D., Cleveland; University of Cincinnati College of Medicine, 1910; age 71; died February 15; former member of the Ohio State Medical Association. Dr. Littell was a practicing physician for about 30 years in the Lakewood area. He previously practiced in Cincinnati.

Ruth A. Maher, M. D., Columbus; Ohio State University College of Medicine, 1952; age 46; died February 18. Dr. Maher was a registered nurse before she received her medical degree and became a practicing physician in Columbus. For a number of years she was a nurse at the former St. Francis Hospital, and during World War II served in the Army Nurse Corps. Survivors include her mother, two half-sisters, a brother, two sisters and a half-brother.

Everett H. Morgan, M. D., Marion; Starling Medical College, Columbus, 1903; age 81; died February 11; former member of the Ohio State Medical Association and the American Medical Association; past-president of the Northwestern Ohio Medical Association; member of the National Association of Coroners. Dr. Morgan had been a practicing physician in Marion since 1919. Prior to that he was in St. Paul, Minn., and still earlier practiced in West Virginia. During the last several years of his practice in Marion he also was county coroner. He was a veteran of the Spanish-American War and during World War II attained the rank of major in the Army Medical Corps. Affiliations included memberships in a number of organizations, among them the United Spanish War Veterans, American Legion, Veterans of Foreign Wars, Eagles Lodge, and the Episcopal Church. Surviving are two sons, a daughter, a brother and a sister.

Daniel J. O'Leary, M. D., Toledo; Stritch School of Medicine, Loyola University, 1935; age 49; died February 21; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. A native of Toledo, Dr. O'Leary served all of his professional career there. He was a member of the Elks Lodge and the Catholic Church. Survivors include his widow, four daughters, a son and a brother.

Elmer A. Powell, M. D., North Baltimore; Illinois Medical College, 1902; age 85; died February 13; former member of the Ohio State Medical Association. Dr. Powell practiced medicine for 39 years in North Baltimore and vicinity. He was one of the original members of the Wood County Board of Education and served on that board for many years. For 22 years he was president of the local Board of Education. He also was a charter member of the local Rotary Club. A veteran of World War I, he was a member of the American Legion, and was active in several Masonic bodies. Survivors include a daughter and a son, Dr. Avery D. Powell, Tiffin; also two brothers.

Wesley C. Ramsey, M. D., Kent; University of Wooster, Medical Department, 1889; age 95; died February 11; former member of the Ohio State Medical Association. A native of Hopedale where his father was a physician, Dr. Ramsey practiced there for 14 years before he moved to Kent in 1913. He previously practiced for short periods in Cleveland and Akron. He was a Mason and a member of the Methodist Church.

Samuel C. Smith, M. D., Ada; Starling Medical College, Columbus, 1897; age 84; died February 3; former member of the Ohio State Medical Association and the American Medical Association. Dr. Smith had been a practicing physician in Ada and vicinity for nearly 60 years. He was a member of the Masonic Lodge, the Modern Woodmen of America and the Methodist Church. Surviving are two daughters, a sister and two brothers.

Ralph Eugene Wharton, M. D., Mansfield; Western Reserve University School of Medicine, 1933; age 47; died February 19; member of the Ohio State Medical Association and the American Medical Association; member of the International College of Surgeons, and the American Academy of General Practice. A practicing physician in Mansfield for a number of years, Dr. Wharton was a veteran of World War I, having served in the Army Medical Corps. He was a member of the Presbyterian Church, the Elks Club, several

Masonic bodies and the Westbrook Country Club. Survivors include his widow, three sons, his mother, a brother and three sisters.

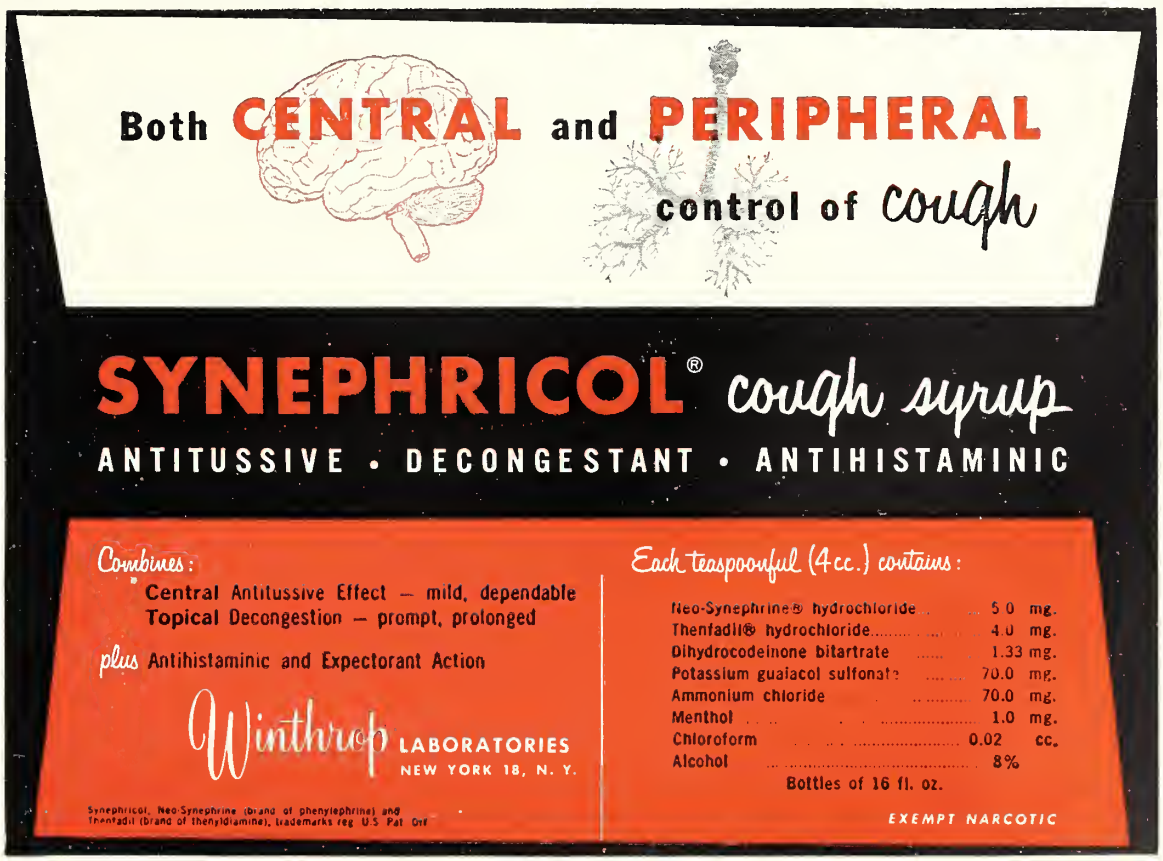
William Albert Yinger, M. D., Rosewood; Starling Medical College, Columbus, 1904; age 79; died January 31; member of the Ohio State Medical Association and the American Medical Association. A native of the vicinity, Dr. Yinger served all of his professional career in the Champaign County area. He was honored two years ago by the Champaign County Medical Society when he was presented the 50-Year pin of the OSMA. He was a member of the local Board of Education and the Evangelical United Brethren Church. Survivors include his widow, a daughter, a son, Dr. Starling C. Yinger of Springfield and a brother.

Guy S. Wilcox, M. D., Ada; Toledo Medical College, 1900; age 86; died February 15; former member of the Ohio State Medical Association and the American Medical Association; recipient of the 50-Year Award of the OSMA. Dr. Wilcox was a native of Hardin County. He began his practice in Archbold. In 1903 he moved to Columbus Grove where he remained until 1917. After service during World War I, he moved to Ada. Affiliations included memberships in the Kiwanis Club and the Methodist Church. A daughter and a sister survive.

Saranac Lake Symposium

The Sixth Annual Symposium for General Practitioners on Tuberculosis and other Chronic Pulmonary Diseases will be held in Saranac Lake, New York, from July 8 to 12. It is approved for 26 hours of formal credit to members of American Academy of General Practice. Further information and copies of the program may be obtained by writing Dr. Henry W. Leetch, General Chairman, Symposium for General Practitioners, P. O. Box 11, Saranac Lake, N. Y.





Activities of County Societies . . .

First District

(COUNCILOR: FRANK H. MAYFIELD, M. D., CINCINNATI)

HAMILTON

The Academy of Medicine of Cincinnati announced the following features which were part of the business meeting held on March 19 in the College of Medicine Auditorium:

"A Proposal for a Permanent Health Museum in Cincinnati," presented by Dr. Charles A. Sebastian, past-president of the Academy.

"The Jenkins-Keogh Bill," The Honorable Gordon H. Scherer, U. S. Representative for the First Ohio District; and Mr. Charles Hartsock, Cincinnati Bar Association discussant.

"The Medical Witness." the AMA film concerning medico-legal matters, presented by Mr. Robert C. Beirne, Cincinnati Bar Association.

At the March 5 meeting the Academy was honored by the presence of Sir Edward Victor Appleton, vice-chancellor of the University of Edinburgh, Nobel Laureate.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

CLARK

Through a public relations program and through office contacts with patients, members of the Clark County Medical Society are urging that all children and adults under 40 receive polio inoculations, whether from private physicians or through public health offices. The inoculation programs of the Springfield and Clark County public health departments have made notable progress. As many as 500 inoculations have been administered in a single clinic of the departments. Upon request, the program is now being carried into the schools.

Upon recommendation of the Executive Council and with approval of the membership, the Society has retained legal counsel on a permanent basis.

To ease the financial hardship for patients who lost their livelihood with the shutdown of the local Crowell-Collier Publishing Co. plant, Society members adopted a policy of extending accounts and making special arrangements for payment.

Dr. Paul W. Schanher, Jr., has been elected second vice-president of the Community Welfare Council. He was succeeded as chairman of the organization's Health Division by Dr. A. T. Anton.

Speaker at the February meeting of the Society was Dr. Henry E. Wilson of Ohio State. His subject was "Clinical Significance of the Palpable Spleen."

At the January meeting, members heard a discussion of "Clinical Problems in Hypertension" by Dr. Albert A. Brust of Atlanta.

DARKE

The subject "Atherosclerosis" was discussed at the February 19 meeting of the Darke County Medical Society in Greenville. Speaker was Dr. G. Douglas Talbott, Dayton.

MIAMI

Dr. Floyd Beman, of the Department of Internal Medicine, Ohio State University, was guest speaker at the March 8 meeting of the Miami County Medical Society. His subject was "Differential Diagnosis of Jaundice."

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The March program of the Academy of Medicine of Toledo and Lucas County included the following features:

March 1: Specialties Section—"Low Back Pain," a panel discussion with the following participants: Drs. Max T. Schnitker, Thomas Brown, Albert Bershon, Franklin Earnest and Robert Ulrich.

March 8: Frederick Melvin Douglass Foundation—"Some Remaining Controversies in Biliary Tract Surgery," Dr. Ralph F. Bowers, chief of the Surgical Section, VA Medical Teaching Group Hospital, Memphis, Tenn.

March 15: Medical Section—"Changes Which Occur in Cirrhosis of the Liver," Dr. Carroll M. Leevy, Medical Center, Jersey City, N. J.

March 22: Surgical Section—"Principles of Diagnosis and Treatment of Diseases of the Neck," Dr. Danely P. Slaughter, associate professor of surgery, University of Illinois.

March 29: General Section—Joint meeting of the Toledo Bar Association and Academy of Medicine.

SANDUSKY

Dr. Walter Hartung, Jr., Toledo, addressed the January 16 meeting of the Sandusky County Medical Society in Serwin's Restaurant, Fremont. His talk dealt with procedures and interpretations of pregnancy tests.

Announcements included the second annual all-day Sandusky County Medical Conference scheduled for April 17.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

CUYAHOGA

Members of the Academy of Medicine met on March 15 at the Medical Library Auditorium

for an afternoon program, dinner and evening session.

The afternoon program consisted of a series of presentations on the subject "Immunization Procedures for Infants, Children and Adults," with Dr. Walter Heymann, as moderator. The following physicians participated, presenting the subjects as indicated:

"Smallpox and PDT," Dr. John H. Kennell.

"Poliomyelitis, Rubeola, Rubella and Infectious Hepatitis," Dr. Frederick C. Robbins.

"Rabies," Dr. Harry S. Ginsberg.

"Influenza, APC and Mumps," Dr. William S. Jordan.

"Tuberculosis," Dr. R. C. McKay.

The evening address was entitled, "Practical Applications of the Principles of Immunization," and was given by Dr. Geoffrey Edsall, director of the Division of Communicable Diseases, Walter Reed Hospital, Washington, D. C.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

TRUMBULL

The February Trumbull County Medical Society meeting was held in conjunction with the Trumbull County Corydon-Palmer Dental Society. As usual it was a dinner meeting and the subject was fluoridation of the Warren water supply. It was an interesting meeting with the dentists actively participating. The Societies were unanimously in favor of fluoridation. Plans were formulated toward bringing the subject before City Council.—Ralph H. Jamison, M. D., chairman of public relations.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

The Scioto County Medical Society met on February 11 for a buffet supper and program at the Nurses' Recreation Hall, of the General Hospital, Portsmouth. Program arrangements were by Dr. B. U. Howland.

A dinner meeting was held at Harold's Restaurant on March 11. Speaker was Dr. Eugene H. Swanzey, Hamilton, Montana, whose subject was "The Staphylococcus and Its Antibiotic Resistance."

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

RICHLAND

Members of the Richland County Medical Society met at Mansfield General Hospital Thursday, February 21. A business meeting was conducted by Dr. Harry Wain, president, following which the Program Committee presented Dr. Martin P. Sayers, of Columbus, who spoke on "Recent Advances in Treatment of Congenital Neurological Disease."

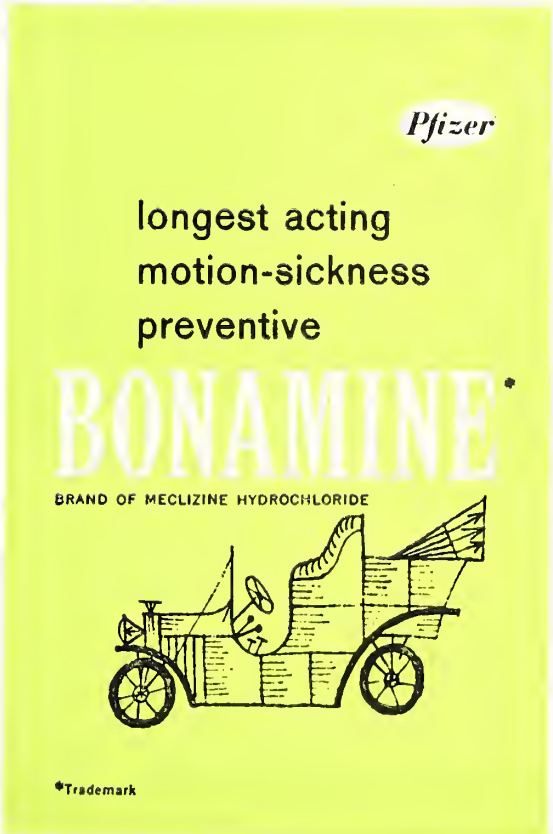
The January meeting was held on the 17th at Mansfield General Hospital, and the speaker was Dr. Don M. Hosier, of Columbus. His subject was: "Pediatric Cardiology."—R. E. Frush, M.D., Secretary.

Resolutions Should Be Sent To Columbus Office Now

Delegates or members and County Medical Societies having resolutions for introduction into the House of Delegates at the 1957 meeting of the Ohio State Medical Association May 14, 15 and 16, Columbus, should, if possible, transmit such resolutions as soon as possible to the Columbus Office so the proposed resolutions can be published in the May issue of *The Ohio State Medical Journal* and copies sent in advance to all members of the House of Delegates.

The above is a recommendation contained in the By-Laws of the Association.

Compliance with the recommendation will help to expedite work of the House of Delegates and provide delegates with advance information as to what questions may be brought before the house for action.



Activities of Woman's Auxiliary . . .

CHAIRMAN, PUBLICITY COMMITTEE—Mrs. Carl F. Goll, 1001 Granard Parkway, Steubenville, Ohio

President—Mrs. William H. Evans, 291 Park Ave., Youngstown

President-Elect—Mrs. V. R. Frederick, 145 Tanglewood Dr., Urbana

Vice-President: 1—Mrs. C. H. Bell, Mansfield
2—Mrs. W. R. Gibson, Oak Harbor
3—Mrs. C. A. Colombi, Cleveland

Recording Secretary—Mrs. Lester W. Sontag, Livermore St., Yellow Springs

Corresponding Secretary—Mrs. Earl Young, 170 Brookline Ave., Youngstown

Past-President and Finance Chairman—Mrs. Karl Ritter, 1420 Shawnee Rd., Lima

CLINTON

D. L. Parker, Clinton County sanitarian, was guest speaker at the meeting of the Auxiliary to the Clinton County Medical Society February 5, at the General Denver Hotel. Mr. Parker spoke on sanitation and some of the problems which are handled in his department, and distributed illustrative literature.

During the business session, plans were discussed for the Clinton Memorial Hospital Ball which will be held April 27 at the Snow Hill Country Club, with Mrs. H. Richard Bath and Mrs. W. L. Wead as co-chairmen. The Decoration Committee will consist of Mrs. E. K. Yantes, Mrs. J. Foster Boyd and Mrs. Frank G. Plymire and the Food Committee will be comprised of Mrs. W. L. Regan, Mrs. V. E. Hutchens, Mrs. Roy D. Goodwin and Mrs. L. H. Fullerton.

COLUMBIANA

Officers were elected by the Auxiliary of the Columbiana County Medical Society at their joint dinner meeting, February 19, at the Wick Hotel at Lisbon. They are:

Mrs. V. C. Hart of Salem, president; Mrs. W. S. Banfield of Irondale, president-elect; Mrs. A. P. Falkenstein of Salem, vice president; Mrs. Robert Osmundsen, also of Salem, secretary; and Mrs. H. F. Banfield of East Liverpool, who was retained as treasurer.

The nominating committee included Mrs. John A. Fraser, chairman and Mrs. J. Fraser Jackson, both of East Liverpool, and Mrs. F. R. Crowgey of Salem.

"The Humane Touch" was the topic of an address by the Reverend Paul T. Gerrard, pastor of the First Presbyterian Church at Lisbon.

Donations totaling $275 were reported by Mrs. Horger of East Liverpool, president.

In line with state and national projects, the




no pain . . .
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No Nightmare of Fear
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group gave $250 to the American Medical Education Fund and $25 for the state nurse recruitment plan.

Fund raising projects will include dances both in the Salem area and East Liverpool. A "Gardenia Dance" will be held at the Country Club April 6 and will be open to the public.

FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Society entertained the residents of the County Home with a valentine party on February 15.

Howard Stucky showed a film entitled "Our Ohio Heritage," obtained from the Ohio Division of Wildlife and Conservation of Natural Resources.

The Auxiliary served refreshments and presented games, embroidery, and flowering bulbs to the residents.

LUCAS

The annual dinner dance of the Aeademy of Medicine of Toledo and Lueas County, restricted to members of the Academy, was an event of February 2 at the Commodore Perry Hotel.

The program featured a play, produced by members of the Auxiliary to the Academy of Medicine and the cast included doctors and their wives; Eddie and Ruth Hanf directed the show.

MAHONING

The Woman's Auxiliary to the Mahoning County Medical Society had a luncheon and style show which was held at the Jade Room, V. F. W. on February 19. Guests were invited for this occasion. The program chairman was Mrs. Earl Young, co-chairman, Mrs. F. A. Friedrich. Vivian's Fashions of Glenwood Avenue presented the show and Ester Sontag was moderator. The Auxiliary members were models.

PORTAGE

Three representatives of the Woman's Auxiliary to the Ohio State Medical Association, offieers and members of the newly organized Portage County Medical Auxiliary with their husbands enjoyed a dinner-danee at Twin Lakes Country Club, Kent, on February 23. Music was furnished by the Club's new high fidelity system.

At the dinner, the county constitution was presented and the county charter was offieially granted by the state President, Mrs. William H. Evans.

Other state officers who were in attendance included Mrs. C. A. Colombi, third vice-president; and Mrs. Myron W. Thomas, chairman, members-at-large.

County officers present were: Mrs. Myron W. Thomas, president, Garrettsville; Mrs. Edward Meachem, Kent, vice-president; Mrs. David Palmstrom, Ravenna, secretary; and Mrs. Joseph Fiala,

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Kent, Treasurer; Dr. David Palmstrom, Ravenna, advisor.

The Woman's Auxiliary proposes to cooperate with the Portage County Medical Society and the Ohio State Medical Association in the protection of public health, the promotion of public education, and the advancement of the other aims of these organizations.

RICHLAND

One of two major social events enjoyed annually by the doctors of the county and their wives was a dinner party held January 31 at the Mansfield-Leland Hotel with the Woman's Auxiliary to the Richland County Medical Society acting as hostess group. At the other party, the doctors act as hosts to their wives.

Mrs. R. D. Campbell was chairman of the hostess committee for the affair. She was assisted in making plans by Mrs. Milton C. Oakes, Mrs. Paul Lee, Mrs. Robert Ellison, Mrs. Donald Adair and Mrs. F. M. Wadsworth. The latter is president of the Richland County Medical Auxiliary. Mrs. Campbell serves as program chairman of the Ohio Medical Auxiliary.

Dr. and Mrs. M. D. Shilling, Ashland, members-at-large of the state organization, were guests at the dinner party.

ROSS

Mr. Leonard L. Freeman of the Chillicothe High School faculty addressed the Woman's Auxiliary to the Ross County Medical Society following dinner on February 14 at the Lynne House.

Goals and aims of the counseling program at CHS were discussed by Mr. Freeman, guidance counselor and history teacher.

Mr. Freeman averred doctors' wives may be very helpful in interesting girls in nursing careers and suggested formation of a future nurses club. He pointed out there are 130 available scholarships at the high school not being used. Mrs. Robert Swank, chairman of the nurse recruitment committee, introduced Mr. Freeman. She also reported on a survey the Auxiliary made concerning scholarships offered by local organizations. She noted that locally, there are 14 gifts, loans or scholarships available to students.

Mrs. Lewis Coppel, president, conducted the business meeting and announced the gems baby-sitting packets, which the Auxiliary has ordered for use by "Y" groups, have arrived. The packets include plays, skits and programs on good baby-sitting. Mrs. Coppel also announced the health reporter radio program has been changed to Tuesday mornings.

Mrs. William J. Corzine, Jr., reported on the sale of *Today's Health* magazine.

Mrs. Robert P. Giesler announced progress is being made on the brochure the Auxiliary is compiling for patients entering Chillicothe Hospital.

Mrs. David McKell, chairman, conducted a short

Cook County
Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES — SPRING, 1957

SURGERY—Surgical Technic, two weeks, April 29. May 13. Surgery of Colon & Rectum, one week, May 6. General Surgery, two weeks, May 6, one week, May 13. Surgical Anatomy & Clinical Surgery, two weeks, June 17. Thoracic Surgery, one week, June 10. Esophageal Surgery, one week, June 17. Breast & Thyroid Surgery, one week, June 17. Gallbladder Surgery, three days, June 24. Surgery of Hernia, three days, June 27. Fractures & Traumatic Surgery, two weeks, June 17.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, June 17. Vaginal Approach to Pelvic Surgery, one week, June 10. General & Surgical Obstetrics, two weeks, May 6.

MEDICINE—General Review Course, two weeks, April 29. Electrocardiography & Heart Disease, two week basic course, July 8. Hematology, one week, June 17.

RADIOLOGY—Diagnostic X-Ray, two weeks, April 29. Clinical Uses of Radioisotopes, two weeks, May 6.

CYSTOSCOPY—Ten day practical course by appointment.

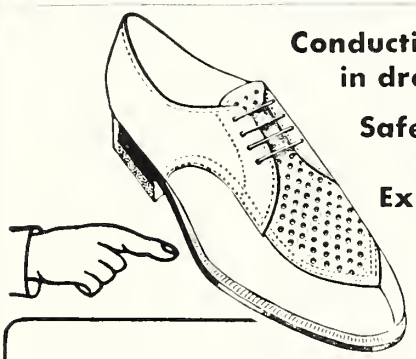
PEDIATRICS—Two-week general course, May 13. Neuromuscular Diseases, two weeks, July 8.

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business meeting of Hospital Guild 1 following the Auxiliary meeting.

SUMMIT

Woman's Auxiliary to Summit County Medical Society held a luncheon meeting in the Sheraton-Mayflower Hotel on February 5.

Following the luncheon meeting, Mrs. Robert B. Hosier introduced the guest speaker, Dr. John L. Caughey. Dr. Caughey is associate dean of the School of Medicine of Western Reserve University and assistant professor of clinical medicine. In his subject, "Educating Tomorrow's Doctors," Dr. Caughey told how medical education has evolved in response to changes in medical knowledge and to the health needs of the community.

Mrs. R. J. Hemphill gave a brief summary of the plans for "Health Days." The theme for "Health Days" this year is "Health Is Our Greatest Heritage." Some 50 health and welfare agencies will be exhibiting. Last year the attendance at "Health Days" was 8,600 of which 1,660 were school children.

TUSCARAWAS

Plans for Tri-County Nurse Recruitment Week, February 24 - March 2 were announced when members of the Auxiliary to the Tuscarawas County Medical Society met February 19 in the Uhrichsville Presbyterian Church.

Mrs. C. J. Miller of this city read a letter from the superintendent of the County Sanatorium, thanking the Auxiliary for the Christmas treats which were given to the patients there.

Auxiliary members voted a $100 contribution to the American Medical Educational Fund and $10 each to the Polio, Heart, Red Cross, Mental Health and Cancer Funds.

Program chairman for the meeting was Mrs. C. J. Nicosia of Bowerston, who showed an interesting film entitled "The Story of Scio," which showed the making of dinnerware from the molds to the finished product and the unity of the employer and employee.

Assisting Mrs. Nicosia as hostesses were Mrs. D. K. Lindberg of Uhrichsville, Mrs. Dan Hostetler of Sugarcreek, Mrs. B. A. Marquand and Mrs. Myrtle Hahn of this city. Mrs. Jane Bates of Dover was an additional guest at the meeting.

Woman's Auxiliary To Meet In New York, June 3-7

The Woman's Auxiliary to the American Medical Association will meet in New York, June 3-7, concurrently with the AMA. Headquarters for the Auxiliary will be the Hotel Roosevelt at Madison Avenue and 45th Street.

Social events include a tea on Monday, June 3; Luncheon on Tuesday at which Dr. Howard Rusk will speak; Luncheon on Wednesday at which AMA President Dwight H. Murry will speak; and the Auxiliary Annual Dinner on Thursday, for Auxiliary members, husbands and guests.

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Phenacetin	120 mg.
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Salicylamide	150 mg.
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The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

January 29—Arby L. Bailey, Cleveland, University of Michigan; Jack C. Bass, Columbus, Washington University; John W. Berghuis, University of Michigan; Doris A. Berlin, Toledo, Medical College of Virginia; Melbourne J. P. Burnett, East Liverpool, Tufts College;

Robert M. Chambers, Columbus, Creighton University; George T. Conger, Akron, Cornell University; Leslie R. Eber, Cleveland, University of Budapest; Karl M. Forster, Girard, Creighton University; George G. Graham, Cleveland, University of Pennsylvania;

Frank L. Jett, Cincinnati, St. Louis University; Wallace E. Johnson, Dayton, University of Maryland; Joseph L. McDaniel, Cleveland, Columbia University; Howard B. McWhorter, Cincinnati, University of Louisville; Fernando L. Mendez, Jr., Cincinnati, Northwestern University; William R. Murphy, Jr., Akron, George Washington University;

James R. Nicholas, Cincinnati, Indiana University; Robert R. Schwalenberg, Jr., Tiffin, University of Rochester; Jacob Seltzer, Akron, Temple University; Ralph T. Streeter, Dayton, Washington University; William K. W. Sullivan, Cleveland, Vanderbilt University;

Theodore E. TePas, Cleveland, St. Louis University; E. Michael Truman, Jr., Hamilton, Indiana University; John H. Wells, Youngstown, Meharry Medical College.

COMING MEETINGS

1957 Annual Meeting, Ohio State Medical Association, Columbus, May 14, 15 and 16.

American Medical Association, Annual Session, New York City, June 3-7.

American College of Surgeons, Course on Fractures, Chicago, April 10-13.

American Neurological Association, Atlantic City, N. J., June 17-19.

Medical Education Week, April 21-27.

Northern Tri-State Medical Association, Annual Meeting, Toledo, April 11.

Ohio State University Medical College Alumni, Reunion, Columbus, April 27.

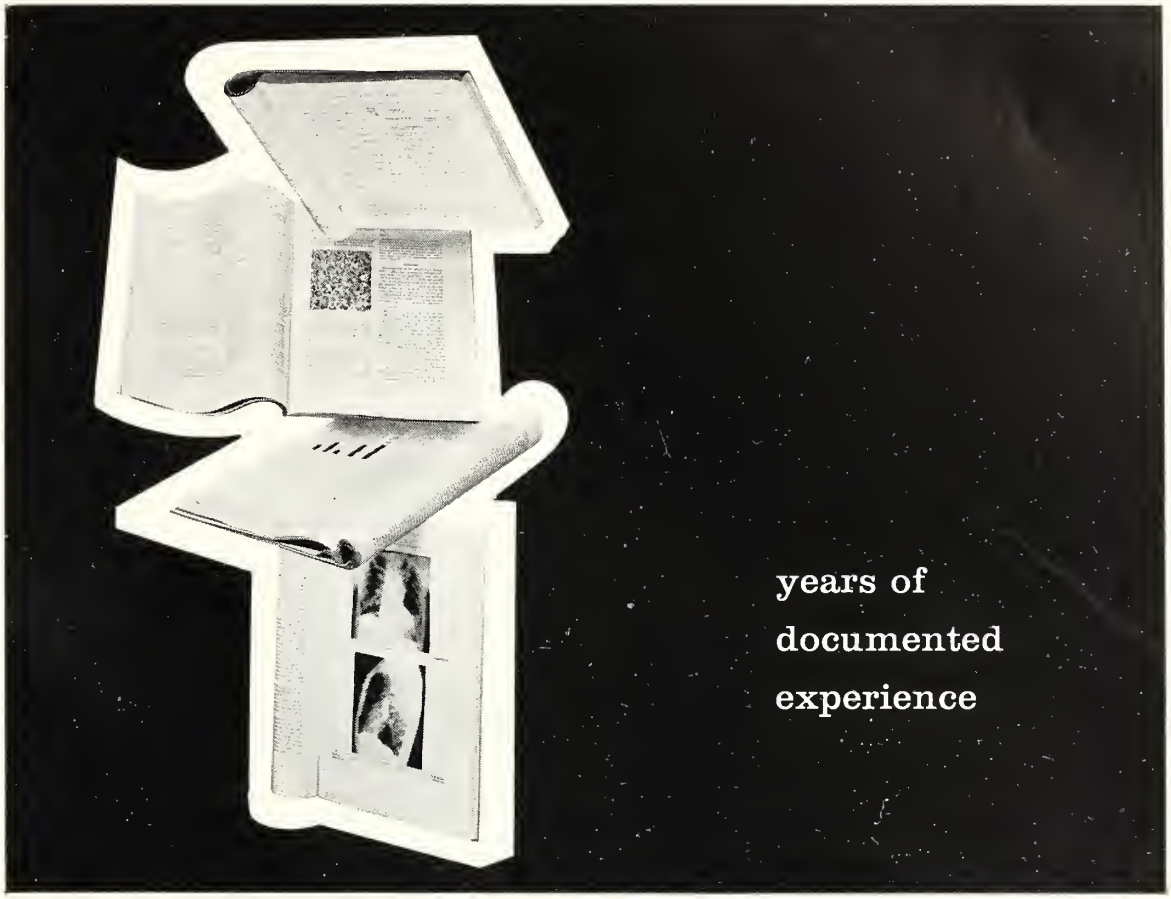
Ohio State Medical Golfers' Association, Annual Tournament, Columbus, June 21.

Seminar on Venereal Disease, Dayton, April 17.

Veterans Administration Clinical Conferences, Cleveland, weekly on Wednesdays.

INDEX TO ADVERTISERS

Abbott Laboratories	390-391, 485
Ames Company, Inc.	384
Appalachian Hall	492
Ayerst Laboratories, Inc.	474
Baker Laboratories, Inc.	467
Burroughs, Wellcome & Co. (U.S.A.) Inc.	375, 400, 496
Ciba Pharmaceutical Products, Inc.	503
California State Personnel Board	491
Coca-Cola Company	501
Columbus Pharmacal Company	484
Cook County Graduate School of Medicine	487
Corn Products Sales Co.	497
Davies, Rose & Co., Ltd.	488
Desitin Chemical Company	395
Endo Products, Inc.	494
Ethicon, Inc.	377
Flint, Eaton & Company	385
Foot-so-Port Shoe Company	487
Geigy Pharmaceuticals, Inc.	495
Harding Sanitarium	396
Hoffmann-LaRoche, Inc.	Insert between pages 496 - 497
Knox, Chas. B., Gelatine Co., Inc.	493
Lakeside Laboratories, Inc.	373
Lederle Laboratories and Insert Between Pages	434-435, 489, 388 - 389
Len-A-Pe Village	481
Lewal Pharmaceutical Company	394
Lilly, Eli, and Company	404
Loma Linda Food Company	500
Mallard, Inc.	472
McMillen Sanitarium	396
Medical Protective Company	486
Merck Sharp & Dohme	380-381, 399, 477
New York Polyclinic Medical School	471
Parke, Davis & Company	386-387, 504 and Inside Back Cover
Patch, The E. L., & Co.	502
Pfizer, Chas. & Co., Inc.	378-379, 393, 473, 475, 479, 483
Picker X-Ray Corporation	398
Riker Laboratories, Inc.	397
Sanborn Company	401
Sawyer Sanatorium	392
Schering Corporation	382-383, 403
Scroggins, Clayton L., Associates (Medical-Dental Management)	498
Searle, G. D., & Company	463
Smith, Kline & French Laboratories	402 and Back Cover
Squibb, E. R., & Sons, Division of Olin-Mathieson Chemical Corporation	465, 499
Stoneman Press	492
Tutag, S. J., & Company	501
Wallace Laboratories	Insert Between Pages 436 - 437
Wendt-Bristol Company	486
Windsor Hospital, Inc.	469
Winthrop Laboratories	481, 498



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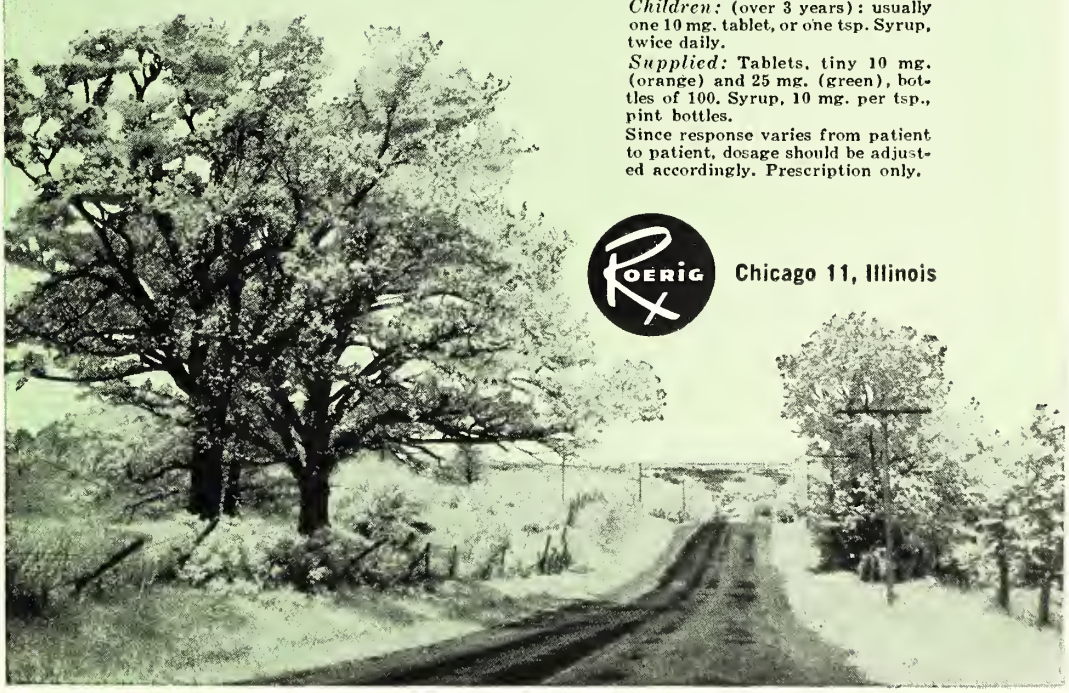
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In order to satisfy these extremely high nutritional requirements, "protective" foods supplying liberal amounts of protein, vitamins, and minerals should predominate in adolescent diets.[3] Such foods include meat, poultry, fish, milk, eggs, vegetables and fruits, and whole-grain or enriched cereals and enriched bread. Accessory foods commonly eaten by adolescents to satisfy emotional needs may provide energy, but are commonly responsible for obesity and should not take the place of the "protective" foods.

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1. Toverud, K. U.; Stearns, G., and Macy, I. G.: Maternal Nutrition and Child Health. An Interpretative Review, Washington, D.C., National Research Council, National Academy of Sciences, Bull. No. 123, 1950, p. 115.
2. Proudfit, F. T., and Robinson, C. H.: Nutrition and Diet Therapy, ed. 11, New York, The Macmillan Company, 1955, p. 271.
3. Martin, E. A.: Roberts' Nutrition Work with Children, Chicago, The University of Chicago Press, 1954, pp. 231-236.

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Personality Changes Following Frontal Leucotomy, by P. Macdonald Tow, Ph. D. (med), M. B., ($8.00. *Oxford University Press, New York 11, New York.)* To resolve the question of the indication for this operation; and the ultimate effects upon the individual the author has written this book. Not only is it a survey of the technical details of the operation, illustrated by cerebral radiographs of unusual clarity, it also presents the long time follow-up on these patients after operation.

Excitability of the Heart, by C. MacBrooks, B. F. Hoffman, E. E. Suckling and Oscar Orias with a foreword by Carl J. Wiggers, M. D. ($6.50. *Grune & Stratton, New York 16, N. Y.)* With a common theme each chapter has been written as an independent unit but each section is complementary rather than interdependent. It is a book which all who have any interest will want to study.

Dentistry: As I See it To-day, by A. LeRoy Johnson, D. M. D., A. M., D. Sc. ($2.50. *Little Brown and Company, Boston 6, Mass.)* The Dean of the Harvard School of Dentistry is known as a rare blend of practitioner, teacher, investigator, so these essays of his are most important to all who are concerned about the future of this branch of medicine. At one time or another the majority of people in this country suffer from dental disease. Over the years methods have been perfected and materials produced which make possible remarkable substitutions for lost dental tissue. This has made dental surgeons out of most dentists when the social need has been for dental physicians. I have met only one dentist who devoted himself to the underlying constitutional and nutritional problems of the patient and sought to prevent rather than patch up the results of dental disease.

Management of Strokes, by Keith W. Sheldon, M. D. ($3.00. *J. B. Lippincott, Philadelphia 5, Pa.)* This is a compilation of material recently appearing in **The American Practitioner.** The author rightly quarrels with the word *stroke.* He pleads for a scientific diagnosis and for treatment appropriate for the lesion presenting itself. One is ashamed to use the word "stroke" and of the foggy thinking that goes with it when one looks at the author's three page outline classifying the so-called "strokes."

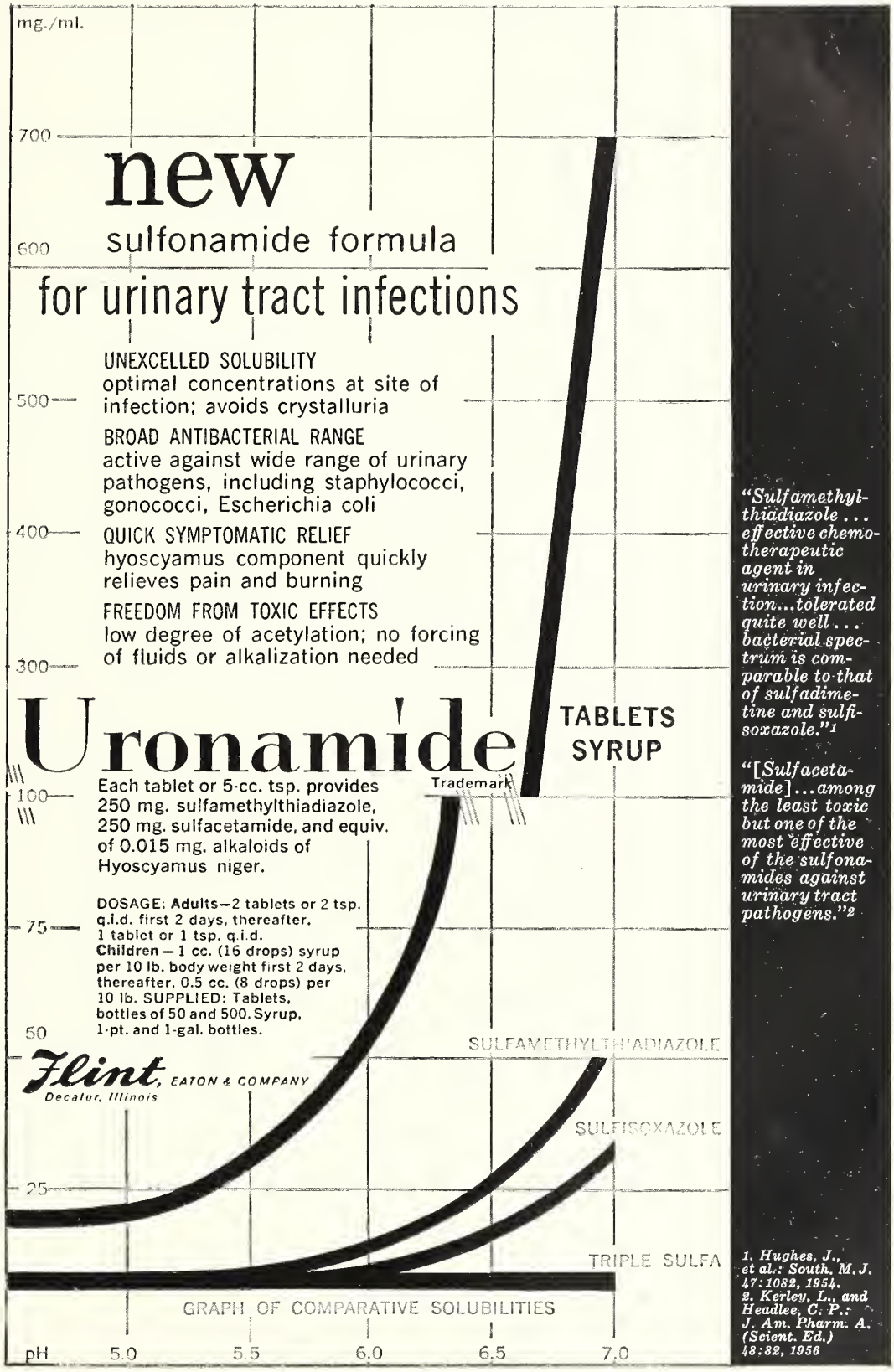
Tell Me Doctor, by Henry Barnard Safford, M. D. (35 cents. *Pyramid Books, 444 Madison Ave., New York 22, N. Y.)* A gynecologist takes his readers into his consultation room and answers intelligently the most intimate questions about the most "delicate matters."

Tomorrow's Food, by James Rorty and N. Philip Norman, M. D. ($3.95. New Revised Edition. *Devin-Adair Company, New York, N. Y.)* This is a book containing many excellent chapters on the current problems of the quality of foods in nutrition. One of great interest to the physician who is concerned about the quality of the American diet is the chapter on bread and its enrichment. There is also a study of the present pressure to fluoridate the public water supply. Rorty, who is an excellent reporter and scientific writer, shows how the minds of biochemists and politicians work, and how they are able to get endorsement from our professional societies. Welfare workers are trained to try to do a little good to a lot of people, whereas we physicians have been trained to think always of the individual patient and to try to do a lot of good to the single individual. The result is a conflict in viewpoint, and sometimes in ethics. It has always been very difficult for your reviewer to stomach the idea of taking some two dozen essentials out of wheat flour, and then returning half a dozen of them under the name of enrichment. The procedure has never been honest, but we must admit that white bread today with its pseudo "enrichment" is better than white bread without any supplements. You are also urged to read the chapter on fluoridation of the public water supply.

The 1955-56 Year Book of Endocrinology, by Gilbert S. Gordon, M. D., Ph. D. ($6.00. *Year Book Publishers, Inc., Chicago 11, Ill.)* This is another worth-while survey of the field of endocrinology. Its format and its content are up to the usual standards of this worth-while series. It offers an excellent opportunity for the busy physician in other fields to make an overall picture of this rapidly developing field in a short time.

The Legacy of Sigmund Freud, by Jacob Arlow, M. D. ($2.00. *International Universities Press Inc., New York 11, N. Y.)* This monograph is the work of the Freud Centenary Committee of the American Psycho-Analytical Association. It is directed to the general public rather than to

(Continued on Page 520)


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1. Hughes, J., et al.: South. M. J. 47:1082, 1954.
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Cytology and the Life History of Bacteria, by K. A. Bissett, D. Sc. ($6.00. Second Edition. *Williams and Wilkins, Baltimore 2, Md.)* The second edition of this monograph includes a considerable amount of new information which serves to confirm and expand the general theories of cell structure and behavior in bacteria, which the author advanced in the first edition some six years ago. More than anything else, it is a report of the author's own observations, although it does synthesize the available information.

Histamine, edited by G. E. W. Wolstenholme and Cecilia M. O'Connor. ($9.00. *Little Brown & Co., Boston, Mass.)* This is a Ciba Foundation Symposium held jointly with the Physiological Society and the British Pharmaceutical Society in London in honor of Sir Henry Dale. The people participating are from all parts of the world, so that the symposium was an international occasion. Our researches in Histamine seem to be at a point at which important advances can be anticipated. Therefore to all physiologists, pharmacologists, and allergists, this book is most important.

Antibiotics Annual 1955-56, edited by Henry Welch, Ph. D., and Felix Marti-Ibanez, M. D. ($10.00. *Medical Encyclopedia Inc., New York, New York)* The proceedings of the third annual Symposium on Antibiotics sponsored by the U.S. Department of Health, Education and Welfare. These 1,000 pages cover pretty completely the current knowledge of antibiotics therapy.

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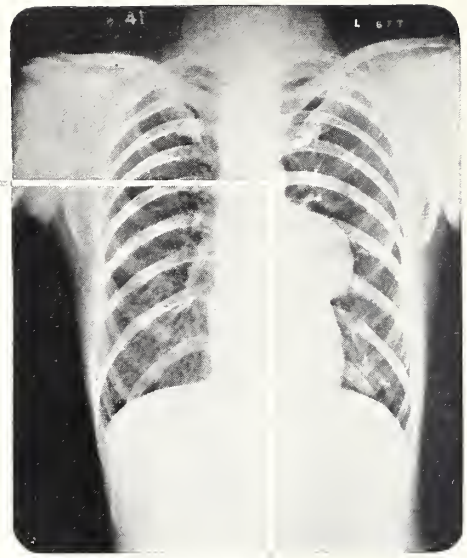
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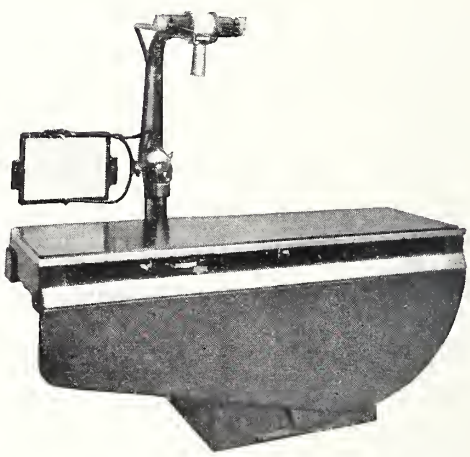
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Silent Myocardial Infarction—A Case Report With a Brief Review of Literature

M. P. SAMBHI, M.B.B.S., and HENRY A. ZIMMERMAN, M.D.

HISTORICAL BACKGROUND

IN the early seventeenth century William Harvey[1,2] observed that the Primum Vivens and Ultimum Moriens of Aristotle was devoid of any painful sensation because he could touch the heart of an injured young man through his open chest without producing pain. Quoting Aristotle and arguing in favor of him, he further remarks about the complete sovereignty of a heart that receives no sense or motion from the brain because it is the first part of the body to exist and start function.

The complete elucidation of the mechanism of referred pain of cardiac origin waited for Sir John MacKenzie[3] in the early part of the present century.

The very earliest traceable mention of symptomatology in a case of death occurring due to occlusion of coronary arteries is devoid of the chief symptom of the syndrome, namely the pain. This was in 1700 by Bonetus[4] in the second edition of his *Sepulchretum*, where he described a case of a middle-aged poet who succumbed in a few minutes after the onset of "distress in breathing" and at the autopsy showed calcified coronary vessels which were almost if not completely occluded.

William Heberden's[5] (1768) excellent account of Angina Pectoris perhaps delayed the recognition of myocardial infarction as a separate entity. Though the diagnosis of coronary thrombosis was made by Hammer[6] in 1876, the clinical description was surprisingly delayed until the pioneer writers of the syndrome, Obrastzow and Straschesko[7] described it in 1910. They divided the symptomatology into three groups: (1) Status Angiosus, (2) Status Dysnepticus, (3) Status Gastalgicus, and included a remark that the disease may occur apparently without pain. Herrick[8] in 1912 who was the first to give a complete description of the clinical entity wrote "cases with little or no pain have been described." He further suggested that sudden occlusion of a vessel by a thrombus causes much more profound symptoms as compared to a gradual arteriosclerotic occlusion.

During the 1920's and 1930's the concept of

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The Authors

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● Dr. Zimmerman, Cleveland, is director of the Marie L. Coakley Cardiovascular Laboratory and chief of the Cardiovascular Section, Department of Medicine, St. Vincent Charity Hospital.

painless myocardial infarction became very popular and received a wide comment. Under this nascent enthusiasm, the definition of painless infarction was stretched to its peak elasticity, to include old infarcts, coronary thrombosis without myocardial infarction and cases where pain was described as any other form of discomfort. As high as 61 per cent incidence of this entity was reported by Bruenn et al.[9] in 1936. Gorham and Martin[10] confirmed such high incidence of the condition by reporting it as 42 per cent two years later.

MECHANISM OF PAINLESS INFARCTION

Various explanations were offered for the genesis of painless infarction. Parkinson and Bedord[11] and East and Bain[12] (1928) in the same years explained that pain of myocardial infarction may be entirely marked by severe dyspnea in cases of heart failure.

Keefer and Rensik[13] in the same year pointed out that myocardial infarction could occur so slowly that only few fibers are injured at a time and this may not produce enough sensation to be interpreted as pain. Libman's[14] hyposensitive individuals were quoted by many as possible candidates for painless infarctions.

Gorham and Martin[10] (1938), in the same publication referred to earlier, tried to support the old mechanical theory of tension as origin of cardiac pain as against the theory of Ischemia by Sir Thomas Lewis.[15] The myocardium, they argued, is free from any apparent sensory fibers, while such fibers do lie in the advential layer of coronary arteries and send branches to smooth muscle of the arterial wall. By experiments on dogs, the authors stated they could produce typical pain merely by mechanical tension with no changes in blood flow. They hypothesized further that this theory could form a better foundation for Herrick and later Keefer's explanation of a very gradual sclerosis of vessels and actual degeneration of nerve fibers in painless cases.

INCIDENCE

More recently in the following decades the pendulum seems to have swung to the other side. While the criteria for so-called painless myocardial infarction were improved and made more rigid, a growing doubt was nourished about the very existence of such a condition. In fact, Warner[16] in 1951 reported 200 cases of myocardial infarctions and he found typical pain in all but nine cases. In all these nine cases, when criteria applied rigidly, he could account for absence of pain. While he did not claim that painless infarction could not occur in an otherwise healthy individual, he suggested that it should be regarded as a rare condition.

Marchand[17] in a recent article, after commenting on varying reports of the incidence of myocardial infarction, reports that in his study of 99 psychotic patients who suffered from acute myocardial infarction, 65.7 to 82.5 per cent had painless attacks. He concluded that to these patients meaning of pain was lost. Painless myocardial infarction has similarly been reported in immediate postoperative period.[18]

OCCULT VS. SYMTOMATIC INFARCTION

Cornello Papp[19] in 1952 reported seven cases out of a total of 150 who had painless myocardial infarction. Three out of these patients had superadded congestive heart failure and acute dyspnea and the other four had onset of complete heart block. He further explained that in the first three cases, the acute dyspnea overshadowed the pain and in the latter four patients, complete heart block with the resulting cerebral anoxia was responsible for the absence of pain. He concluded that if criteria for painless myocardial infarction are applied rigidly, it perhaps is a rare occurrence.

In spite of the massive literature existing over the question of painless myocardial infarction, there is a striking paucity of a well defined comment on entirely silent one. In fact, on looking through the literature, we could find no such case reports in the English literature about entirely silent cases alone. Several observers like H. Marvin Pollard et al.[20] and George Souliner[21] have mentioned few asymptomatic cases in their painless groups, the majority of whom had some other type of discomfort. Some observers have used the term *silent* synonymously with *painless*. Most of such reports at any rate have been reviews of a group of patients of the past.

On making a diligent search, we could find only one case report in the German literature[22] of two entirely asymptomatic cases detected to have acute posterior myocardial infarction on routine electrocardiographic diagnosis. It is our purpose to present such a case in this paper.

CASE REPORT

Case No. 1 A 54 year old white married male was admitted to St. Vincent Charity Hospital on the 19th of June, 1955, for elective surgical repair of left inguinal hernia. As a preoperative routine, he was referred to our chief cardiologist for evaluation as an operative risk.

There was not anything remarkable in his personal, past, or family history. He denied all symptoms referable to the cardiovascular system such as dyspnea, orthopnea, chest pain, discomfort or oppression, ankle edema or postprandial distress.

On physical examination, he was a well built and nourished, not obese individual. Temperature was normal. He had a regular sinus rhythm with pulse rate of 100 per minute. Blood pressure was 168 systolic, 108 diastolic. Vital capacity was 3,000 cc. or 70 per cent of calculated normal. Fundi showed some old exudations, scarring, and pigmentation more on the left than the right which was thought to resemble an old choroidoretinitis. Lungs were clear. There was normal precordial activity. Heart size was clinically judged as upper limits of normal with apex

beat in the midclavicular line. A_2 was greater than P_2. No murmurs were heard. Abdomen was negative. His peripheral vessels were palpable and pulsating normally.

He was diagnosed as having hypertensive and arteriosclerotic heart disease. The routine 12 lead electrocardiogram taken showed acute anterior myocardial infarction. (See Fig. 1 and Fig. 2)

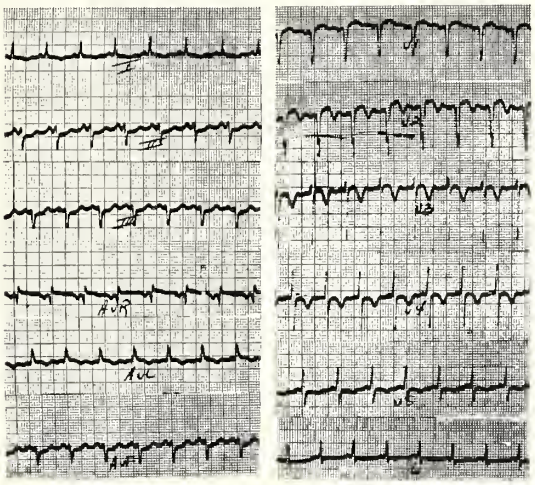


Fig. 1. Admission electrocardiogram, taken June 20, 1955. Note the T wave changes; indicating a recent antero-septal myocardial infarction.

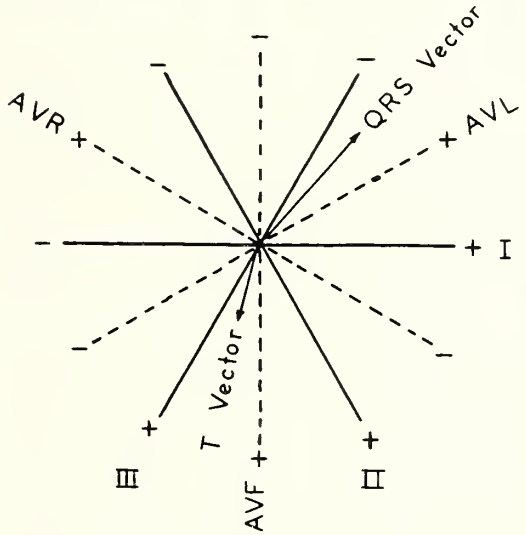


Fig. 2. Frontal plane vector analysis of admission electrocardiogram. Note the angle between the QRS and T vectors.

The patient was placed on a coronary regime of treatment. He was placed on bed rest and anticoagulant therapy instituted. C re-active protein estimation on June 25th and 27th were plus 2. It was repeated on July 12th and was reported as negative. The patient had no temperature elevation. The total leukocyte count remained within normal limits. The patient was discharged on July 20th in good condition and has been followed since.

Repeat electrocardiogram on November 30th after a four month period is presented showing the changes of an old anterior infarction (Fig. 3). During this visit, the pain sensitivity test of Libman was performed on the patient. We would like to add that to all practical purposes the patient displayed a normal apprehension and discomfort towards ill health.

DISCUSSION

Silent infarction, if rigidly defined, what Von Bruno Kish[11] called "Ocult Infarction," is certainly nothing else than rare. It is not our purpose to comment on its incidence but we wish to point out that it certainly occurs in other than psychotic and postoperative patients. These may be entirely asymptomatic individuals. This perhaps adds to the value of routine electrocardiographic examination on susceptible age groups.

There have been many suggestions referred to earlier in the literature suggesting the genesis of silent infarction. Several people have conjectured about these being Libman's hyposensitive individuals. We did not, however, come across any mention in literature where assessment was made of such cases according to criteria described by Libman.[14]

The test for sensitivity of pain in an individual as described by Libman is as follows: The test is carried out by pressing the thumb against the tip of the mastoid bone and then slipping the index finger forward and pushing it medially against the styloid process. Pressure on normal mastoid bone causes no pain and therefore serves as a control. If it does cause pain, the individual is classified as unduly sensitive.

It is important not to rub the bone because rubbing the periosteum of any bone is apt to cause pain. Pressure in the direction of styloid process is painful to normal individuals. Sensitive point is really not the styloid process but a

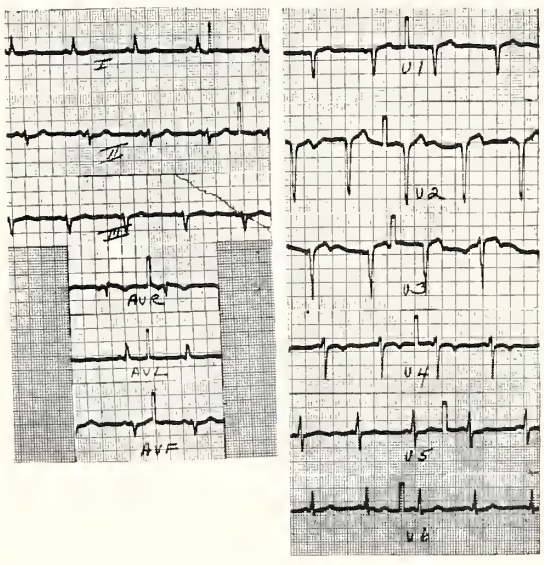


Fig. 3. Follow-up electrocardiogram, taken November, 1955. Note the reversal of T wave and ST segment changes. Also note the shortening of R wave in V-3 and V-4, indicative of the healed myocardial infarct.

branch of the greater auricular nerve crossing it. Individuals on the basis of their response can be classified into three groups.

Group	Response	Classification	
I	No pain	0 sensitivity	Hyposensitive
II	Pressure or little pain	+ sensitivity	Hyposensitive
III	Pain	+++ sensivitivity	Normal sensitivity

The term insensitive is not employed. ++ is left out to make a good margin of distinction between hyposensitivity and sensitivity. No distinction is attempted between +++ and greater, such as ++++, etc. The test should be repeated always twice after an interval and done on both sides.

In our patients, the test was performed according to the preceding instructions, taking two patients on the ward recovering from recent myocardial infarction with typical painful attacks as controls. The controls were chosen to be nearly the same age groups and as far as we could determine, of the same level of intelligence and apprehension. The results were as follows:

		Right	Left
Patient	1	+++	+++
	2	+++	+++
Control No. 1	1	+++	–
	2	+++	+++
Control No. 2	1	+++	+++
	2	+++	+++

We conclude from the foregoing that our patients had normal sensitivity to pain and it seems apparent to us that so-called hyposensitivity could hardly account for painless infarction.

Whether it is the presence of adequate collateral circulation as suggested by Blumgart,[23] or it is the unusually slow occurring process, involving small areas at a time, postulated by Keefer et al.,[13] or yet another unknown cause to account for it, is a pathological mystery.

SUMMARY

A review of literature on painless myocardial infarction is presented. An attempt is made to define the term "painless" clearly. One well documented case of painless and otherwise entirely asymptomatic myocardial infarction is reported and discussed.

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Untoward Reactions to Antibiotics In the Treatment of Infections

Antibiotics are no exception to the rule that any drug is potentially dangerous. Indeed, their properties and actions are such as to make them unusually capable of producing undesirable side-effects.

The efficacy of the antibiotics in routing infection has led to their widespread, often indiscriminate use and, as a result, a sizeable segment of the population has been exposed to them repeatedly, with consequent sensitization and development of drug allergy. The increase in occurrence of hypersensitivity reactions, ranging from urticaria to fatal anaphylaxis, poses a growing threat to the usefulness of these potent agents, particularly penicillin.

Unfortunately, there is available no reliable test that will indicate sensitivity to an antibiotic; it often is necessary either to rely upon an inaccurate history of a purported reaction or to run a risk of confirming the story by bitter experience. Other than to recognize drug allergy for the serious problem it is, and to issue a plea for the use of antibiotics only when distinctly indicated, and not as placebos or antipyretics, there is little that can be done.

In certain serious infections such as that of bacterial endocarditis in which prolonged administration of an antibiotic to which the patient is known to be allergic means the difference between life and death, the concomitant administration of adrenal steroids sometimes will suppress serious reactions, making a course of therapy feasible. This measure should be reserved for desperate situations, however, when no other solution is possible.—Ivan L. Bennett, Jr., M. D., Baltimore, Md.: *West Virginia M. J.*, 53:55-62, February, 1957.

School Health Is a Community Undertaking

THOMAS E. SHAFFER, M.D.

NEVER before have we who are interested in children's health had so much for so many as we have today. The young consumers of child health services are at an all time high. In 1955 almost 4,100,000 babies were born, a record for this country. The 1,532,000 marriages in 1955 presage bumper crop of babies this year. The lives of children are safer today than ever before too.

Babies born this year can expect to live 70 years thanks to advances in immunization procedures, the long list of "miracle drugs" and many public health improvements. Among the less well-recognized advances is the progress that has been made in surgery for children. Countless lives are saved or improved every day by all sorts of surgical techniques which 10 years ago would have been considered impossible and even fantastic.

Despite the great number of lives saved by treatment, an even greater number are saved by preventive measures. Within my memory, preventive medicine was considered a subject for postdoctoral study in postgraduate schools of public health. Now there is scarcely a single medical school in this country that does not have an undergraduate department of preventive medicine. Preventive medicine and public health are the business of the general practitioner and the specialist alike today.

KEYSTONE OF PREVENTIVE MEDICINE

Unheralded but significant in our progress in furthering child health has been public education about health and child care. Health education indeed is a keystone of preventive medicine and the unbelievable reduction in deaths among babies under one year of age could never have been accomplished without a vigorous program of education of parents. Public health nurses have done this great job of creating interest in improving the health of infants. Now we must enlist a larger force to educate about improving the health of preschool and school age children.

Another factor contributing to the improvement of child health and child care is the organization of our resources for children. How can we better organize these resources? Family physicians, hospitals, health departments, public and private schools, voluntary health agencies, youth organizations and the parents of the children all can contribute to the promotion of child health.

One of the most notable advances in recent years has been the organization of these for a common purpose. The speciality of pediatrics established as the study of the diseases of children now reaches far beyond medical care. Pediatrics could not function without assistance and participation from specialists in other fields in the problems of children outside the strictly medical field. A significant step, in my opinion, has been the re-christening of the Department of Pediatrics at the University of Edinburgh, Scotland, with the title "The Department of Child Life."

The Author

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A BROADER CONCEPT

Due to these advances, health problems of children as we see them today are not what they once were. This means the objectives of health services for children cannot be the same as they once were. We have too long looked at mortality rates as an evaluation of health progress but I ask you, is longevity indeed a reward in itself? Is it enough simply to live 70 years, and meet the statistical expectation, if one lives those 70 years with defects which could have been remedied or reduced?

One may question whether the results of preventive medicine can be measured simply by the number of lives saved. This standard would make preventive medicine a narrow field limited simply to inoculations, sanitation, and quarantine. Death is one thing but health is not a single entity on the other side of the ledger. There are degrees of health. Children who consider themselves well and even appear so, may actually be far below optimum health.

The term *preventive medicine* is actually a rather negative sort of concept. It signifies nothing but maintaining the status quo. We are being challenged now by a new concept of preventive medicine. Preventive medicine loses its negative implication of simple defense against harmful influences and assumes a positive character, when we include in its sphere control of progression of health impairments.

The best descriptive term to embrace this new broad viewpoint of preventive medicine is *constructive medicine*. This is a phrase and a viewpoint

Presented as the keynote address, Third Ohio Conference on Physicians and Schools, at Lake Hope, Zaleski, May 8, 9, 10, 1956.

I ask you to remember as we discuss health of school age children, child health, public health, and preventive medicine today and tomorrow. For everyone there is a maximum or optimum state of health—today we have a right to work toward that end.

School health some sixty years ago was a program of inspections for contagious diseases in the schools. That was public health in the narrow sense of the term because the only measures then employed were sanitation, quarantine, and vaccination against smallpox, the sole immunizing procedure available at this time.

We have come a long way from that period to the present era, when for example, the New Haven Board of Health (1950) officially stated that "Measles, German measles, mumps and chicken pox must be allowed to occur in childhood rather than attempt prevention with the alternative of having them contracted in adolescence or adulthood. These diseases have no preventives and adolescents and adults are being attacked in greater numbers and with greater severity. Therefore, many health authorities do not deem it advisable to exclude from school contacts of these diseases."

PREVENTION IN INFANCY

These same authorities pointed out that the serious contagious diseases of childhood are preventable by immunization but they were quick to state that the time for prevention through immunization is in infancy and not in the school years. This viewpoint of a Board of Health in a leading city is a sign of the times and a hint for a periodic re-evalution of our methods in school health. School health is, I like to think, the offspring of one old parent *(Education)* and one young parent *(Pediatrics)* and, therefore, should be observed carefully lest its growth and development be affected adversely in this ambivalent home environment.

Many years ago health programs in schools in the larger cities branched out into a program of case finding in which frequent medical inspections for obvious health problems were carried out in the schools. This interest of schools in pupils' health was of course earnestly undertaken because children who are below par do not become good pupils. The weakness with the early programs of this sort in the schools was that what took place in the school was impersonal and did not take into consideration the important role of the family and the community health agencies in carrying through on the findings of the school.

The result was that there was no follow-through to treatment; children and their parents received false security from believing that they had a medical examination and many children actually lost respect for medical examination and for health supervision because they perceived the superficial nature of the school examination. Many children were needlessly alarmed by remarks or attitudes of the examiners when a simple, short explanation would have calmed them. There was no positive, desirable health education experience in the inspection for the parents or for the child. Said more briefly, I believe, this adds up to the fact that the child can be lost in the shuffle of simply looking for physical defects.

SO-CALLED LESS SERIOUS DEFECTS

Today the *real* health problems of the school age child are not those which threaten his life, require hospitalization, or even mean absence from school. Most important health problems of school age children do not cause symptoms sufficient to make the child or his parents seek medical attention. Yet those defects may interfere seriously with optimum growth, development and education. We are challenged with the almost impossible task of discovering unrecognized defects or those which the child or his parents know about but take philosophically. Furthermore, in the concept of Constructive Medicine, we must find them early enough to prevent progression to advanced stages.

Experience shows that in 100 children of school age, one has a heart disorder; 20 have visual disorders; 10 have hearing impairments; 15 have nutritional disturbances; 10 have growth problems; 85 have dental disease; and 20 have emotional disturbances.

In addition, there are those who are only partially immunized, all those children who live on the borderline of good hygienic practices and those who do not get enough sleep, recreation or fresh air and sunshine. In what lies ahead, we must take account of disorders such as these which are especially difficult to detect early because there is no natural motivation to secure correction. And the younger the child is at the time of discovery, the more benefit will accrue. Furthermore, many of these health problems of children are not detected by conventional health examinations of the sort that can be casually carried out in a school or even in a doctor's office, without special planning.

Secondly, it is a common finding that people do not follow through on medical recommendations for chronic nonpainful disorders as readily as they do for acute conditions. How can we get people to follow through on advice about their health when they do not have the motivation of pain or fear? We do know that too often families do not understand the significance of the problem and they do not understand what needs to be done. They do not know where to find the recommended treatment; or, they either do not have the funds or are unwilling to pay for the diagnosis and treatments.

It is becoming more and more apparent that education and understanding are the permanently motivating factors which govern behavior. Traditionally, fear of the consequences has been the

most common device for motivating health attitudes and behavior. Perhaps we have overemphasized this emotion and the time has now come for developing the lasting understanding which comes from education.

Thirdly, there is the problem of integrating the school's interest in the health and development of pupils into the community's interest in its future citizens and the family's interests in its children. The child when he reaches school age is not a newcomer for he has been a member of his family and of his community for some years.

CHILD HEALTH BEGINS WITH PARENTS

Child health programs actually begin before the parents are married. Thirty-nine states have laws requiring a premarital health examination and 42 states have a requirement for blood test for syphilis during prenatal care in pregnancy. The prenatal care of an expectant mother is an integral part of child health programs because of the effect on the occurrence of premature births, birth injuries and nutrition of the infants. The care received by newborn infants in hospitals and health supervision during the first two years constitute the basis of the excellent child health programs which have been worked out most places on a community basis.

All of these activities contribute to the healthy development of the child, physically and emotionally. Unfortunately, most of these programs are concentrated on the first two years of the child's life and there is no similar organized attack on the problems of the preschool and the school age children in most places.

The relationship of the school health program to the premarital health examination, prenatal care of the expectant mother, health supervision during infancy and preschool periods seems to me both obvious and exciting. We might term it a "proposal to college" health program. The school is responsible for a long segment of this.

We must also consider the relationship of the school's interest in child health to the health problems faced by the child after school and during vacations. Thus, in addition to the role of the school in the longitudinal course of a child's life, there is the place of the school's health program in the cross section of the child's day.

If there is no medical or public health leadership in the community for the development of child health programs the school people may become leaders because they are the best informed and the most visionary group in the community. I hope their concern does not concentrate solely on the children of school age because this will mean that other resources and services in the community will not be adequately developed.

It is agreed that there should be routine medical check-ups for every child at periodic intervals. Opinion is constantly changing about the frequency of these examinations and most of us feel now that they need not be every year or even every two years. Whether these examinations are done in the office of the family doctor or in the school, or in the town hall varies with the local situation but certain facts are outstanding. These examinations should take the form of a conference or interview with the parent and should include time for a health history.

THE "3-D" LOOK

A health conference which brings results has three phases: The *health history* which indicates what the child *was*, the *health examination* which indicates what he *is* and the *health counseling* which will bring out what he can be. This three-dimensional look at a child, his past, his present and his future, is a far different undertaking than the lineup for impersonal inspection and physical appraisal we see so often.

The examination should be an appraisal made with most of the child's clothing removed. For the pediatrician's viewpoint, the appraisal should be aimed at the real health problems of school age children. These are not the traditionally respected diseases of the heart, lungs, abdomen, skin and skeleton. Instead, they are disorders which hinder children's development and education, many of which require special techniques for diagnosis which are not available in the school or even in the private doctor's office. Fortunately, however, t h e r e are non-diagnostic screening tests which can be used in schools to focus attention on children in need of further examination and to bring out salient features for health education. Interpretation of the findings of health appraisal and discussion of the next steps for securing medical care make it desirable for parents to accompany younger children to the health examination.

DANGER SIGNALS IN APPRAISALS

Take heed that there are some potential hazards in health appraisals which must be considered and evaluated. Are we making neurotic adults through hurried, impersonal examinations and thoughtless comments about physical characteristics which probably are normal? Is physical fitness overstressed so that children who are not in the upper percentiles for physique and strength are made to feel insecure and inadequate? Do we follow up sufficiently on children with *doubtful* physical findings to be sure that unwarranted fears about physical ailments are dispelled by complete examination?

Many children are falsely labeled as cardiac patients; as having poor posture; as being too fat or thin; as having tonsils which need removal —when really they were within the range of normal—all because the examiners either did not know the ranges of normal growth and develop-

ment or they did not take the time to explain to the child and his parents that some variation is normal. **It is as important to reassure those who have no defects as it is to inform and instruct those who do** for the psychological impact of an examination with prolonged special attention to certain organs or areas of the body can cause misunderstanding, anxiety and confusion.

Mental health is paramount and can be promoted through the health examination, as behavior and emotional disorders can be revealed through the history in the interview with the parent.

Health is dynamic, and a medical examination today is no passport or guarantee for good health until the next routine examination. Between examinations, ill health or faulty growth and development can take place insidiously. Continuous appraisal rather than isolated medical experiences best meets the needs of children. Parents, teachers and school nurses all are part of the team which works between the actual examinations. This implies vigorous training programs to teach the techniques and meaning of these observations. These are high standards indeed but they should be our goals. The school physician, for example, can, by being a medical adviser rather than a medical inspector, serve his function not only by giving routine health appraisals but also by aiding teachers and nurses in evaluating children referred to him because of suspected health problems.

The focus of school health programs must move from simple planning for physical appraisals and courses in health education to a comprehensive, coordinated community-wide solution to the health needs of all children, whether or not they have reached the school years.

GUIDING PRINCIPLES

I would like to recommend several general principles to guide school health committees in their planning:

1. The school health program should include a plan of education to bring children and their parents into effective contact with the health and medical resources in the community. The resources should include the physician and dentist who normally serve the child or family.

2. Within the school, there should be continuing efforts (1) to acquaint the staff with existing health facilities and the ways to use them effectively; (2) to understand the importance of the public health unit, especially the *nurse*, in health promotion; and (3) to interest school personnel in the importance of preschool health supervision as preparation for the school period.

It falls upon teachers, nurses and doctors to try to discover the child in need of medical attention and through education and fostering of understanding to assure diagnosis and treatment in the community. In school health programs we are too many times working on the cross-sectional view of the single examination which shows what the child is. Let us in the years to come keep in mind the longitudinal view of the child's past, what he now is, and by all means, let us concentrate on *what he might be.*

Somewhere in this country of ours, there will be born this year, or soon thereafter, a baby who will someday be the President of the United States. He may be born to a home where every advantage is available; he may be born to live in a rural farm house, or in the home of a coal miner or factory worker. If we could look ahead and know who this child is, what would we not do to prepare him for his responsibilities? Every child has a life before him and we cannot predict his future. Let us together use every means we can muster to assure every child the best possible preparation for a productive life.

Accidental Ingestion of Camphor Is Probably Frequent

Camphor poisoning has been reported more than 130 times in medical literature but the frequent presence of camphor containing substances such as liniments and insect repellents suggests that its accidental ingestion is probably more frequent than this number would indicate. Furthermore, most of the reported cases occurred during the nineteenth century. Poisoning has usually followed accidental ingestion, but has been reported after the use of nose drops and after intraperitoneal injection.

Camphor has been used for centuries in Chinese medicine. Its odor probably led to its medical use and the reputation it enjoys even today among some of the laity as a valuable agent for protection against infection.

The pharmacologic action of camphor is stimulation of the central nervous system, and in large doses it produces epileptiform convulsions. The literature on the cardiovascular actions of camphor reveals some disagreement. The blood pressure may fall because of peripheral vasodilatation, or rise slightly because of central vasomotor stimulation. Camphor is probably detoxified in the liver by uniting with glycuronic acid and may appear in the urine as camphoglycuronic acid.

The pathologic effects of camphor upon the brain have been well described by Smith and Margolis, who demonstrated neuronal necrosis in a fatal case of camphor poisoning in an infant. They reproduced these changes in experimental studies in mice and demonstrated that in these animals barbiturates not only prevent convulsions but also protect against neuronal damage. Other studies demonstrated fatty changes in the liver and kidneys.—William P. Blackmon, M. D., and Hiram B. Curry, M. D., Jasper, Fla.: *J. Florida M. A.*, 42:999-1000, April, 1957.

Value of the Midline Planigram for Diagnosis Of a Midline Brain Tumor

A Case Report of Metastatic Tumor, Optic Chiasm*

BERT H. McBRIDE, M.D., and EDWARD C. ELSEY, M.D.

THE value of body section roentgenography in neuroradiology has been well documented. However, the use of this clinical procedure has lagged behind the technical advances. In 1937, Carrillo, Oribe, and Malenchini[1] advised laminography for visualization of the 3rd and 4th ventricles, the cerebellum and the basilar cisterns.

Epstein and Davidoff,[2] in 1946, emphasized the value of the midline tomogram and recommended it as a routine procedure when visualization of the midline structures is necessary. Then in 1953 Poppel, Jacobson, and Dewing[3] encouraged its use in pneumoencephalography and ventriculography because of its superiority in outlining the midline cavities. They were impressed that the lateral midline tomogram had often proven to be the single most valuable film in a series of approximately 20 roentgenograms obtained routinely for ventriculography or encephalography. In only two of 62 cases were the standard views superior. These relative failures were felt to be due to early technical difficulties.

Our experience is limited. However, the procedure in the study of the skull and with contrast studies has frequently given us superior visualization. Technically the procedure is not difficult and, perhaps just as important on a busy service, is not time consuming.

Our paper is a case report of a patient with a small midline tumor. This tumor was not delineated by routine air contrast studies though pinpointed to some extent by the clinical picture. A midline planigram clarified the site of pathology. By planigraphy is meant the technique by which the tube moves one way back and forth in a rectilinear manner.

REPORT OF CASE

The patient, a 68 year old white male, was admitted to Christ Hospital, Cincinnati, Ohio, on June 3, 1955, with a history of having had diabetes insipidus for one year. The onset had been sudden and at the time the patient was thought to have had a stroke. The polydipsia and the polyuria had been well controlled with pitressin.®

Two months before admission he had noted a loss of vision, deafness, and the onset of "dizzy headaches." The deafness was of such severity that it was difficult to communicate with the patient even with the help of a hearing aid. The relatives had observed anorexia and weight loss. There was a recent history of one episode of loss of consciousness for a few minutes. Excessive sleeping was also described.

Physical Examination: Temperature 98.6°; pulse 80; respirations 20; blood pressure 120/64. The patient appeared to be chronically ill. There was evidence of weight loss. He was slightly confused. The deafness was of a high degree bilaterally as noted. Both pupils reacted. Visual acuity was reduced bilaterally. The patient could count fingers at about three feet with the left eye and at about two feet with the right. He could recognize people if they came within close range. One observer felt that on several occasions he had demonstrated a bitemporal hemianopsia. However, later this could not be confirmed. Fundoscopic examination was not remarkable.

Roentgenographic Examination: X-rays of the skull showed a faint pineal calcification which was in the midline. Films of the chest, pelvis and an intravenous pyelogram were negative.

Laboratory Data: Blood, urine and blood chemistries were noncontributory. An electroencephalogram was normal. A Thorn test revealed evidence of depressed adrenal cortex function.

On June 22nd a pneumoencephalogram was carried out. This study was not conclusive and



Fig. 1. Standard, brow up, lateral view, demonstrating the third ventricle and the probable outline of a tumor, but with the details obscured by subarachnoid air.

*From the Department of Pathology, Christ Hospital, Cincinnati.

Presented before the Joint Session of the Section on Neurological Surgery and Section on Radiology, at the Annual Meeting of the Ohio State Medical Association, Cleveland, Ohio, April 10-12, 1956.

The Authors

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Fig. 2. Anteroposterior view of skull, standard technique. This view also failed to demonstrate a tumor mass.

was thereby supplemented by a lateral midline planigram which demonstrated a rounded mass in the anterior portion of the third ventricle which measured 2½ cm. in diameter.

Operation: On June 27th a left frontal craniotomy was performed. A tumor of the optic chiasm and third ventricle was demonstrated as being inoperable. The patient was given cortisone both pre- and postoperatively. His course was downhill and he died of a terminal aspiration pneumonia.

An autopsy was performed and revealed a metastatic lesion of the chiasm. The primary site was found to be an adenocarcinoma of the left adrenal. There were other metastases in the aortic nodes.

SUMMARY

A case report of a midline brain tumor has been presented which demonstrates the advantages of a midline planigram during encephalography. The use of body section roentgenography in cases of suspected midline lesions should be encouraged.

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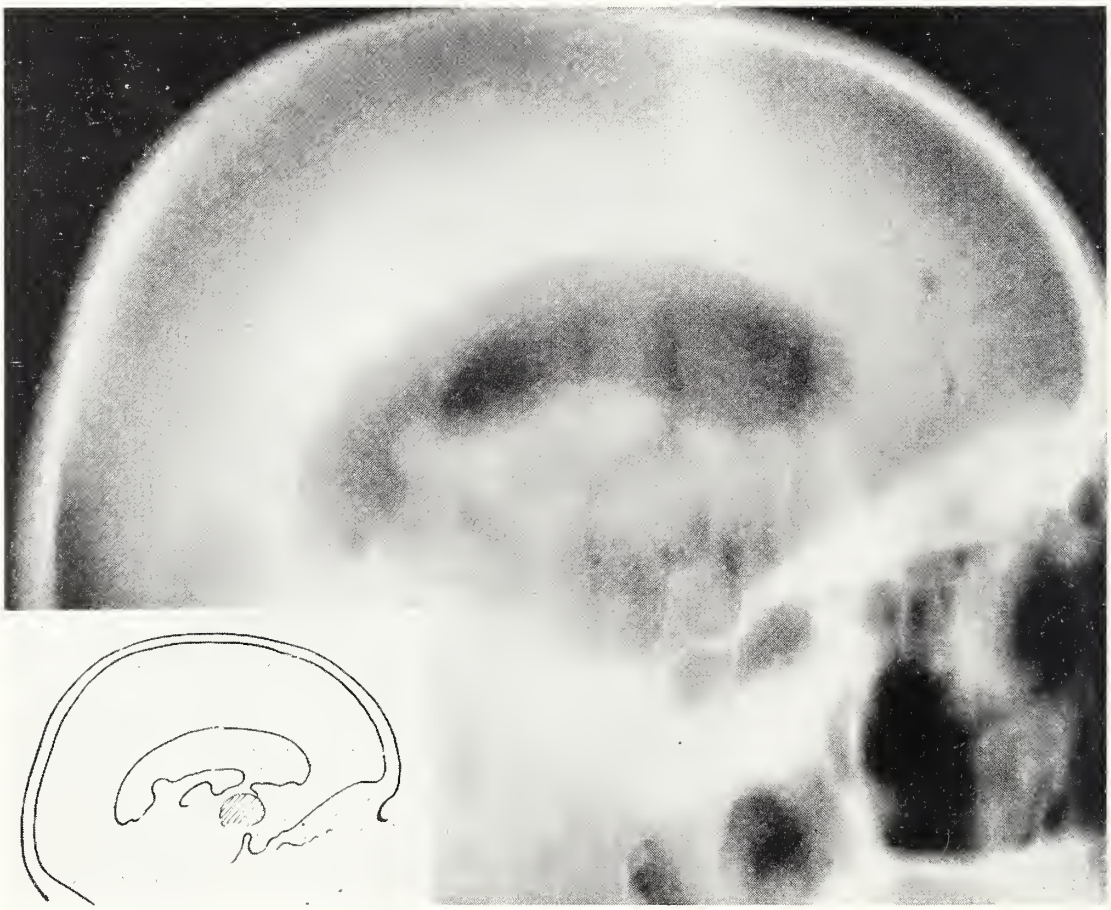


Fig. 3. Midline planigram with the patient in the brow up position. A tumor mass is clearly delineated as distorting the third ventricle.

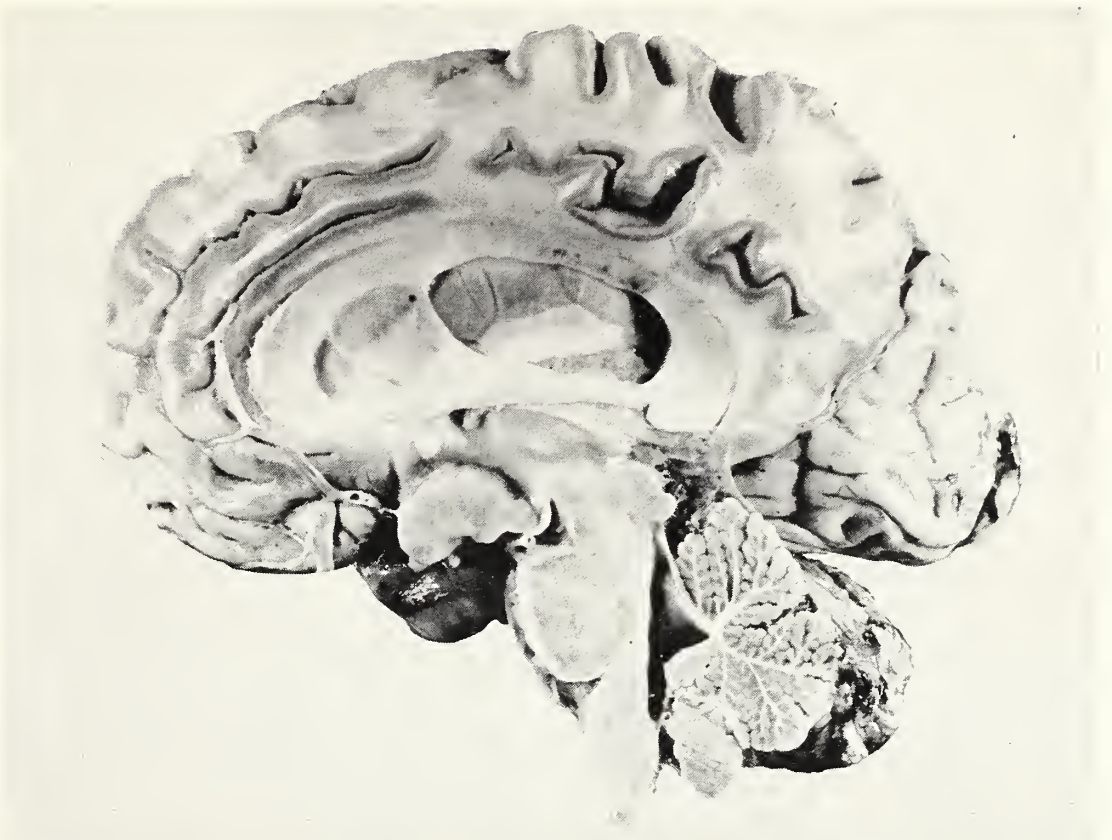


Fig. 4. A mid-sagittal section of the brain at postmortem revealed metastatic involvement of the optic chiasm. An adenocarcinoma arising from the left adrenal was demonstrated as the primary site. **(See preceding page.)**

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D., *Columbus, Ohio, Chairman*

The Franklin County Pelvic Cancer Delay Committee met at the Columbus Health Center on Wednesday, March 20, 1957, at 12:00 noon. Three cases were presented.

Case No. 44: A 47 year old negro female who entered the hospital with the chief complaint of abdominal distension and generalized weakness. The patient had been followed by her physician since eight months prior to admission with these symptoms.

Abdominal examination indicated a large, hard, irregular mass that could be felt rising out of the pelvis and extending up to the left above the umbilicus. The patient's liver was three finger-breadths below the right costal margin. Paracentesis revealed a large amount (approximately 1,500 cc.) of fluid removed. A cell block of spun-down fluid was reported carcinoma compatible with ovarian primary. The patient was treated with intra-abdominal nitrogen mustard.

Comments: DR. FRED HAPKE: Nine months physician delay.

Case No. 45: This patient is a 44 year old white female who first began to have symptoms two years prior to admission. She had irregular periods for two years. No pain, but occasional clotting. She was first seen for medical consultation 22 months after first symptoms. She delayed admission, however, until two months later.

Pelvic examination revealed cervical carcinoma, Stage I. Biopsy revealed moderately well differentiated squamous cell carcinoma of the cervix. Patient is a candidate for preliminary radiation of 5,500 roentgens followed by radical Wertheim resection.

Comments: DR. FRANCIS GALLAGHER: Patient delay of approximately two years.

Case No. 46: A 58 year old white female who developed spotting and bleeding one year prior to admission. The patient, however, did not think it was serious, although she was consulting her family physician regularly for treatment of hypertension. No pelvic examination was done until one year later at which time the patient was referred to clinic because of a gross malignancy in her pelvis. At this time pelvic examination revealed a squamous cell carcinoma of the cervix Stage III.

Comments: DR. JOHN H. HOLZAEPFEL: This appears to be combined patient and physician delay. Certainly if the patient had alerted the physician that she was bleeding, a pelvic examination would have been done. However, a portion of the delay must be attributed to the physician since he did not do a complete examination throughout a period of one year.

Surgery in Pulmonary Tuberculosis*

ELMER R. MAURER, M. D.

SINCE the advent of the "magic" antimicrobial drugs the concept of what constitutes the proper surgical treatment of pulmonary tuberculosis has dramatically changed. As with any revolutionary development the logic of new rationales has been questioned. Prior to the discovery of streptomycin, PAS (para-aminosalicylic acid) and isoniazid the principle of collapse therapy (pneumothorax, phrenic crush, thoracoplasty) was popular and was generally accepted. Surgical excision of a tuberculous lesion was considered hazardous or fatal and was seldom practiced.

With the passage of time and the accumulation of clinical and laboratory experience definite logical programs of pre- and postoperative drug treatment have been established and exact criteria for the application of complementary surgical excision of tuberculous lesions have been defined. Voluminous reports of successful excision of tuberculous pulmonary lesions utilizing a properly supervised antimicrobial "screen" have suggested that such a program is not only safe but gives an excellent cure rate with few complications. In many cases there has been an impressive reduction in the days of sanatorium stay and an earlier return of patients to gainful employment.

MODERN MANAGEMENT OF TUBERCULOUS PULMONARY LESIONS

Generally speaking, at the present time, active pulmonary lesions are intensively treated with antimicrobial drugs and bed rest programs for at least six to twelve months at which time solid or cavitary residuals are excised by wedge, segmental, lobectomy and in occasional instances pneumonectomy techniques. The exact choice of surgical procedure to be applied in many instances must be decided in the operating room. Most often, however, critical preoperative evaluation by special radiographic studies such as tomography, preoperative bronchoscopic and bronchographic examination, bacteriological susceptibility studies and pulmonary function evaluations, allow the surgeon to localize the lesion accurately, establish the best time for elective excision and select the best combination of drugs for administration during the period of surgery.

Preoperative bronchoscopic examination should be mandatory. The presence of active endobronchitis even in the afebrile nontoxic patient would contraindicate surgical intervention until the patient had an additional three to six months of antimicrobial treatment with drugs to which his organisms were still susceptible. The presence of bronchial stenosis would suggest that a lobectomy would be necessary in a patient for whom segmental resection was previously planned. A more than normal quantity of positive sputum in a patient with noncavitary disease by x-ray may result from tuberculous bronchiectasis which could be diagnosed and localized by preoperative bronchographic study.

Pulmonary function evaluations in patients with emphysema, chronic pleurisy, or in individuals in the advanced age group may indicate the substitution of collapse therapy for an open chest excisional procedure which had previously been planned. Such a program of careful evaluation following the usual six to twelve months of accepted antimicrobial treatment will result in a high cure rate and a low incidence of crippling or lethal complications.

INDICATIONS FOR EXCISIONAL SURGERY

As a guide in the selection of lesions to be excised there is now general agreement that the following disorders are best treated by surgical removal:

1. Persistent cavitary disease uncontrolled by medical management.
2. Giant cavity.
3. Destroyed segment, lobe or lung.
4. Tuberculoma (encapsulated, solid residual).
5. Bronchopleural fistula and empyema with destroyed lobe of lung.
6. Tuberculous empyema with destroyed lobe of lung (excision of empyema with lobectomy).
7. Tuberculous bronchiectasis.
8. Collapse therapy failures (pneumothorax, pneumoperitoneum, thoracoplasty).
9. Serious hemoptyses uncontrolled by the usual medical measures.
10. Unfavorably located cavitary disease (superior segment lower lobe or in central portion of lung near mediastinum).

It has been estimated that in 25 per cent of the patients with advanced pulmonary tuberculosis, rest and the administration of antibiotics will fill in the cavities with granulation and fibrous tissue leaving only stellate scars. Viable

*This is one of a series of articles on chest diseases sponsored by the Ohio Trudeau Society, medical section of the Ohio Tuberculosis and Health Association.

The Author

● Dr. Maurer, Cincinnati, assistant clinical professor of surgery, The University of Cincinnati College of Medicine, is chief of the Department of Surgery, Dunham Hospital.

tubercle bacilli are rarely cultured from resected lung specimens in this group of patients and surgery probably is not necessary.

In another 10 to 15 per cent of the patients, resected specimens are positive by smear or culture. Cavities 1 to 2 cm. in diameter are common. It is in this group of patients that surgery offers the best prognosis. In the remaining 60 to 65 per cent of the patients with advanced disease, resected specimens show caseous masses, shrunken cavities with inspissated pus, tuberculomas or large open cavities. In this group prolonged antibiotic therapy is usually necessary before surgery.

Patients with bilateral upper lobe cavitation or "honeycombing" present a particular problem in surgical management. If such patients are otherwise healthy and the pulmonary function is adequate, bilateral surgical excision of the involved portions of lung or bilateral collapse in stage procedures will often result in a cure.

COLLAPSE THERAPY

Extraperiosteal release of the soft tissues of the chest wall without rib resection, followed by insertion of lucite spheres to maintain the collapse and control paradoxical motion of the decostalized chest wall—so-called extraperiosteal lucite plombage—has, generally speaking, replaced the old conventional multistage thoracoplasty in those patients where permanent collapse therapy is the treatment of choice. This procedure permits selective collapse in a single operation without the complications of paradoxical motion or the painful deformities of the chest wall and spine that were so common following thoracoplasty procedures. Lucite plombage, however, has limited application and is generally reserved for those patients who are not candidates for surgical excision because of limited pulmonary function.

All patients regardless of choice of methods of surgical management, should receive a carefully controlled course of antimicrobial therapy for six to twelve months preceding, during, and usually for six months or longer after completion of the surgical program. All patients should be evaluated for need for surgery periodically while under treatment through the joint consultation of the thoracic surgeon and the chest physician.

The Milk-Alkali (Burnett) Syndrome

Milk and alkalies have been used for many years as adjuncts in the treatment of peptic ulcer. For the most part, their neutralizing effect on acid gastric secretion has been favorable and has justified their extensive use. The prolonged, excessive administration of alkalies, with or without milk, however, has occasionally caused certain metabolic complications of clinical importance: 1. Alkalosis; 2. Renal insufficiency; 3. Calcium retention.—M. A. Chapin, Auburn, Me.: *J. Maine M. A.*, 48:76-81, March, 1957.

KEEPING UP WITH MEDICINE

• THERE SEEMS to be no doubt that vitamin B_{12} does exert a growth-promoting effect when given to children in growth failure.

* * *

• NEUROSURGEONS will recall little patients whose migraine was based upon structural changes; allergists will remember patients whose migraine was caused by a food sensitivity; and psychiatrists can recite many instances of psychosomatic origin. The best approach is to invoke all three possibilities. Although it is rare for migrainous children to develop epilepsy later, anti-epileptic drugs are most helpful along with food identification and avoidance while the physician guides the emotions of the patient to safer grounds.

* * *

• IT IS NOW suggested that elective surgery in patients with recurrent hemorrhage from peptic ulcers may be withheld where the hemorrhage follows the use of salicyl compounds, alcohol, or both, since simple withdrawal usually yields a good result.

* * *

• IT IS BEING RECOMMENDED that ACTH is more desirable for initial therapy of acute rheumatic fever for a short time, either alone or together with aspirin, aspirin being continued after the ACTH has been withdrawn.

* * *

• AFTER experimental destruction of esterase by diisopropyl fluorophosphate, its regression is depressed in liver damage.

* * *

• CANCER of the breast is about four times as frequent in women who develop grossly evident breast cysts or who have a family history of breast carcinoma but the only thing that can be done in a practical way for women in these two categories is to attempt to make certain that they take every possible step for early detection. It is possible to train these women to examine themselves for the detection of a cancer of the breast.

* * *

• SOME OBSERVATIONS suggest that the liver and gallbladder are target organs for hypersensitivity reactions.

* * *

• THE MESENCHYMAL REACTION in the liver with viral hepatitis may also be allergic in nature.

* * *

• BLACK HAIRY TONGUE probably is a result of prolonged irritation from mouth washes containing sodium perborate.

* * *

• GENERALIZED LYMPHADENOPATHY is often associated with hypersensitivity to antithyroids; apresoline®; bromides; hydantoin anticonvulsants; hydralazine; iodides; mercurials; PAS; presidon®; pronestyl®; serums; antibiotics; tissue extracts, et cetera.—J. F.

Clinical Notes on a Series of Hemiplegics*

HARRY W. SLADE, M. D.

HEMIPLEGIA has been a subject of considerable study both in the laboratory and clinical investigation. Through these studies many theories, hypotheses, signs and symptoms have been derived. Repetition of this time-honored information will not be undertaken. However, several interesting observations and signs have been observed which do not seem to be generally recognized.

Twenty-nine patients with hemiplegia of cerebrovascular origin were evaluated. This group included 16 males and 13 females. Twenty-six were right handed and three were left handed. The right side of the body was affected in 11 cases, and the left side of the body was affected in 18 cases. The average age of the patients was 60 years, and the average duration of the hemiparesis was 26 months (tables 1 and 2).

TABLE 1.—NUMBER OF PATIENTS—29

Males—16	Females—13
right handed	26
left handed	3

TABLE 2.—SIDE OF BODY AFFECTED

right	11
left	18
Average Age	60 years
Average Duration of Hemiplegia	
2 years	2 months

The patients were divided into three categories in regard to their rehabilitation; good, fair and poor. By good rehabilitation was meant that the patient was able to walk well without assistance or with the aid of a short leg brace or foot drop spring and was able to do at least a limited amount of self care, i. e., dress and feed himself. These three groups were then subdivided as to

TABLE 3.—SUBDIVISION AS TO SENSORY IMPAIRMENT

Rehabilitation	Sensory Impairment	
good - 3	minimal	GROUP I
good - 3	moderate	
good - 7	marked	
fair - 3	moderate	GROUP II
fair - 2	marked	
poor - 3	minimal	GROUP III
poor - 2	moderate	
poor - 3	marked	

2 could not have evaluation

sensory impairment into minimal, moderate and marked (table 3). A detailed evaluation of the modalities involved and the extent of involvement is seen in the charts for Groups I, II, and III.

*This study has been aided by the Cleveland Foundation. Patients were from Highland View Hospital and Cleveland City Hospital.

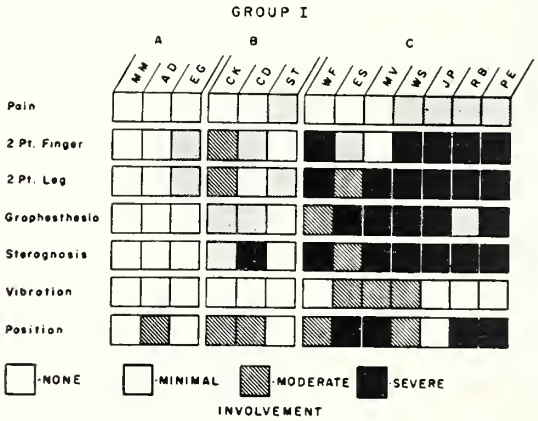
**Presented before the Cleveland Society of Neurology and Psychiatry October, 1955.

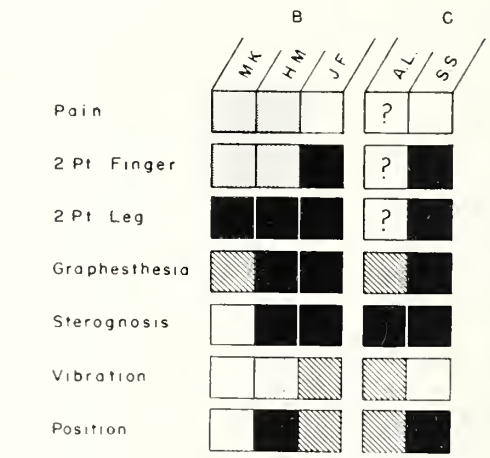
The Author

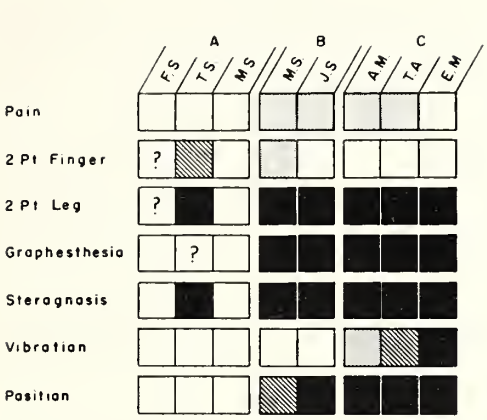
● Dr. Slade, formerly acting chief, Neurosurgical Service, Cleveland City Hospital, and senior instructor in neurosurgery, Western Reserve University School of Medicine, is now in practice at Waco, Texas.

It seems obvious from the accompanying charts that there is a marked discrepancy in the modalities which are involved. Two point discrimination in the upper and lower extremities, graphesthesia, stereognosis, and position sense seem to be much more frequently and seriously involved than are either pain or vibratory sense. It is also seen that the severe sensory involvement does not preclude good rehabilitation, which differs from the reports of other series.[1]

During the evaluation of the motor system there was noted to be a frequent severe involvement of the orbicularis oculi. This weakness was







noted to be more apparent than the weakness of the lower facial musculature in many cases. Thus it was found that the orbicularis oculi showed more apparent weakness to testing than the lower face in 14 cases; the weakness was equal to that of the lower face in nine cases; and was less than the lower face in five cases. A weakness of both orbicularis oculi was noted in one case, but it was noted that this patient had suffered a cerebrovascular accident on the opposite side several years prior to his present illness (table 4).

TABLE 4.—WEAKNESS: ORBICULARIS OCULI VS LOWER FACE

14	greater than
9	equal to
5	less than
1	weakness of both orbicularis oculi.

During the examination of the facial muscles it was noted that there were two cases of compulsive eye opening. After this series of evaluations had been made this phenomenon was reported by Berlin in a recent article.[2] It is believed that a more careful study will reveal that this phenomenon is much more frequent than previously supposed.

Comparison of the weakness of the trapezius and sternocleidomastoid revealed that the trapezius was weaker in the entire series of 29 cases. In only five cases could even a moderate weakness of the sternocleidomastoid be observed. However, in 21 cases there was no demonstrable muscle power in the trapezius; three had slight power; one had moderate power; and only four had fairly good strength.

TABLE 5.—WEAKNESS: TRAPEZIUS VS STERNOCLEIDOMASTOID

	29 - greater than		
21	- no power	4	fairly good strength
3	slight power		
1	moderate power	5	moderate weakness

It was observed that the rehabilitation depended little on the degree of motor activity on the hemiplegic side (table 5). It was also noted that flaccidity made ambulation difficult if not impossible. Flaccidity was observed in only one case. These observations are in agreement with those of Von Buskirk.[1]

An interesting, although not thoroughly explained phenomenon was also observed, namely, paravertebral muscle hypertrophy on the side of the hemiplegia (figures 1 and 2). The ipsilateral paravertebral muscle hypertrophy was graded as shown in the following table 6.

TABLE 6.—IPSILATERAL PARAVERTEBRAL MUSCLE HYPERTROPHY

8	- very marked	4	- moderate
5	- marked	7	- slight
	2 - none		

DISCUSSION

Experimental parietal lobe extirpations carried out in the monkey and chimpanzee have revealed that the higher discriminatory capacities are not confined to a single site. The difference between monkey, chimpanzee and man lies only in the depth and persistence of the deficit. Thus, the fine grades of sensation, more particularly the gnostic aspects, are most affected.[3]

It was observed that two point discrimination in the upper and lower extremity, graphesthesia, stereognosis, and position sense were most severely impaired; whereas pain and vibration, more primitive sensations, were preserved. It was noted that there was no correlation between the degree of sensory impairment and the degree of rehabilitation that was possible.

The explanation for the ipsilateral paraverte-

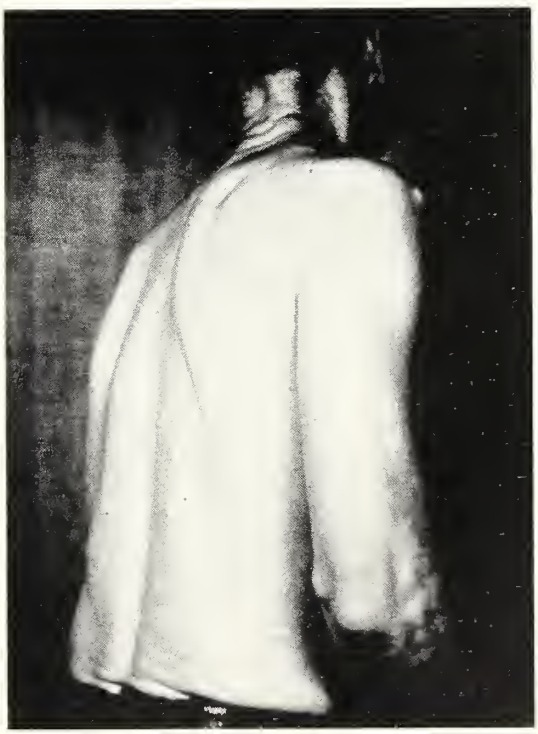


Fig. 1. A 58 year old right handed male with a left hemiplegia of 18 months' duration. Note the left paravertebral muscle hypertrophy.

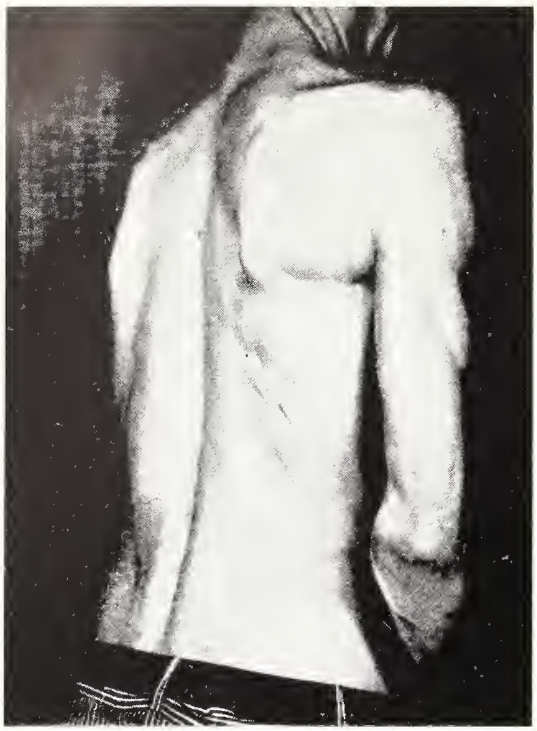


Fig. 2. A 66 year old left handed male with a left hemiplegia of 11 months' duration. Note the left paravertebral muscle hypertrophy.

bral muscle hypertrophy is not well understood. One of the possibilities is that the uncrossed pyramidal tract is responsible for the paravertebral musculature. That this tract is not demonstrable below the cervical levels may be a matter of lack of sufficient technical skill in being able to detect these fibers by the usual staining methods. A second possibility is that the paravertebral musculature receive bilateral innervation very similar to the frontalis. A third possibility is that there is a combination of a slight atrophy of the contralateral paravertebral musculature and slight relative hypertrophy of the ipsilateral paravertebral musculature.

In attempting to seek out the reason for the ipsilateral paravertebral muscle hypertrophy the following explanation seems logical. In order for the individual to use the extremities on the uninvolved side there is need for a fulcrum upon which the force can be exerted. There is likewise need for an anchor of the fulcrum. Thus the spinous processes and vertebrae would serve as the fulcrum and the paravertebral musculature on the opposite side would serve as an anchor for the fulcrum. The paravertebral musculature on one side and the muscles on the contralateral extremity would therefore work synergistically.

SUMMARY

In the study of a series of 29 hemiplegic patients it was observed that the following signs not generally recognized were present on the contralateral side of the cerebrovascular accident:

1. Paresis of the orbicularis oculi in addition to or greater than the lower facial weakness;
2. Disproportionately greater involvement of the contralateral trapezius when compared with the sternocleidomastoid muscle; and
3. Paravertebral muscle hypertrophy.

Involvement of the sensory modalities of two point discrimination, graphesthesia, stereognosis and position on the contralateral side was reaffirmed.

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Habit-Forming Properties of the New Psychotherapeutic Drugs

Of course, it has not been possible to classify these drugs as addictive using the present standards for such a classification. The definition of addiction and the qualifying characteristics of this state have been made with morphine and other narcotics in mind. It has been reported that with most of these ataractic agents there are usually no evident withdrawal symptoms when cessation of therapy is initiated. Rather than the specific physiological absence of the drug, it is a return to the pre-treatment anxiety state which is stressful to the patient.

Lemere has challenged the classification of meprobamate as a non-habit-forming drug and his survey of a small number of patients has indicated that this drug may be considered as habit-forming. He describes a patient who had been taking excessive amounts of meprobamate (6.4 Gm. daily for one month) who had a severe convulsion 10 hours after meprobamate was withdrawn. He also describes patients under the influence of 2.4 Gm. or more per day who demonstrated signs of an alcohol-like intoxication.

Tolerance is usually quite minimal, although Lemere has also described several patients who had to take increasing amounts of this drug in order to continue an effective therapeutic state.

A true physiological dependence has not been described for any of the ataraxics but can one say that a patient who cannot face anxieties unless he is ataractized is dependent on a drug? It is not too unlike the morphine-addict who has had to revert to a narcotic state in order to leave his anxiety-prone environment.

It is too early to make frank statements as regards the habit-forming or addictive properties of this rapidly expanding list of ataraxics. But we should not scoff at the few "brave souls" who have suggested such properties, as many of us did when it was first proposed that the barbiturates might have addictive properties.—Francis W. Hughes, Ph. D., Indianapolis: *J. Indiana M.A.*, 50:293-302, March, 1957.



A CONTINUOUS state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and assisted by official representatives of the various County Medical Societies of the state.

Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, will be published in *The Ohio State Medical Journal* from time to time. Each presentation will be brief but informative. It will contain opinions of the Committee, based on the data submitted for review. In the series of cases, entitled "Other Causes," the three cases in this ninth report have to do with maternal death due to cardiac disease.

CASE NO. 49

This patient was a 20 year old, white, gravida II, Para I, who died 18 hours postpartum. Her past history was not remarkable; her first pregnancy was delivered the previous year, at term, a living baby, without complication of pregnancy, labor or the puerperium. The last pregnancy dated the last menstrual period on the 20th of August (estimated date of confinement May 27), and prenatal care was considered adequate, with four visits to her physician, the first one in her fourth month of gestation. On April 29th (eighth month of pregnancy) she was admitted to the hospital because of a "cold," cough, some edema (all for several days) and the history of a systolic murmur; complained of orthopnea.

Physical examination revealed minimal rales at both pulmonary bases, soft systolic murmur at apex, transmitted to the left axilla. X-ray findings: Heart considerably enlarged, marked increase in pulmonary markings especially at both bases, "apparently secondary to heart condition." Electrocardiogram report: Sinus tacchycardia plus multiple ectopic prematures. Atypical intraventricular conduction defect of variable origin. Evidence of myocardial damage of undetermined etiology, probably acute and reversible congestive heart failure. Probably congenital heart disease; follow-up indicated. Repeat electrocardiogram indicated some improvement. Diagnosis: Pregnancy, congestive heart failure, congestive or rheumatic? BCG test: Reaction abnormal.

On May 7, the patient was discharged, blood pressure 110/70, pulse 100 and fibrillating, fetal heart tones good. Treatment: Crystodigin® and rest.

On May 16 she was readmitted to the hospital by her physician because of dyspnea, and pulmonary congestion, with pedal edema. There was a "long history of old rheumatic heart condition." Physical examination revealed cardiac enlargement to left anterior axillary line, loud systolic murmur at apex, transmitted to left axilla, irregular beat, blood pressure 90/60; fetal heart tones present. Her condition was noted as critical, "may not live to deliver baby; not good enough to induce labor." May 22, her condition was more critical, "holds own in oxygen tent only."

Labor began spontaneously, membranes ruptured spontaneously, delivering a living 5 pound 4½ ounce baby with forceps, after two hours labor. Third stage normal. The patient's condition was listed as critical, in the puerperium; there was only a slight improvement immediately, then the course was progressively worse until she expired the following day. Autopsy permission was obtained.

Pathological Diagnosis: Congestive heart failure; congenital aortic stenosis.

COMMENT

The Committee voted this a nonpreventable death. Little is available on the past history of the patient, especially concerning her course following the first pregnancy, although it was listed as normal; members of the Committee wished to know if the cardiac lesion was noted as early as the fourth month of the patient's pregnancy, and if so, whether or not the case was evaluated from a cardiac standpoint at that time. Furthermore, it was not clear whether or not the patient was considered well enough to be discharged from the hospital May 7th, or whether she should have remained longer.

CASE NO. 25

This patient, a 34 year old, white, Para II, abortus II, Ces. I, died 3 days postpartum (postoperative). In her past history, she knew she had congenital heart disease; because of this a therapeutic abortion had been performed on her in 1942. Her second abortion was spontaneous in 1944. Prior to this she had had a living baby born at term in 1941, while she had delivered a stillborn baby at 30 weeks in 1949; details of

cardiac complications in this pregnancy are not known.

In her last (fifth) pregnancy she failed to seek prenatal care until her thirtieth week of gestation, March 14, when she noted vaginal bleeding! The physician's examination at that time revealed cardiac enlargement but no decompensation; no note was made of blood type or serologic examination. Nor is information available concerning events in the interim.

On March 22, she was hospitalized because of severe vaginal hemorrhage. Vaginal examination revealed placenta previa; hematocrit was 56 per cent; electrocardiogram showed right bundle branch block and premature ventricular beats; fluoroscopic examination revealed enlarged outflow tract of right ventricle, possible pulmonary arteriolar sclerosis.

On March 25, at 3:30 p. m. the membranes ruptured; at 7 p. m. severe uterine contractions appeared with vaginal bleeding; one unit of blood was transfused. At 8:27 p. m., low transverse cesarean section was performed under spinal anesthesia (pontocaine®), and a living 2 pound 8½ ounce baby was delivered; the placenta was found low, and on the right. A second unit of blood was transfused, with intravenous fluids.

The first postoperative day the hematocrit was 47 per cent; on the third day the patient was apprehensive and her pulse rose to 120. Following a sudden pain in her shoulder and chest she died in 20 minutes. (The baby died of prematurity and erythroblastosis.) Autopsy permission was obtained.

Pathological Diagnosis: Interatrial septal defect; organized thrombus right auricle; recent pulmonary thromboembolic emboli; remote myocardial infarct of right auricle.

COMMENT

With a close margin, the Committee voted this case a preventable maternal death (P_1) principally the fault of the patient. It was agreed that the patient should have sought prenatal care at an early date especially since she knew she had heart disease. A question was raised by members of the Committee, "Why was the patient not hospitalized for study, and evaluation, when she was first seen on March 14?"

CASE NO. 84

This patient was a 22 year old, white primigravida who died 32½ days postpartum. Her past history was important; she had had congenital heart disease (Eisenmenger complex) discovered and followed by her family physician since the age of 2. Her last period was April 26th (estimated date of confinement February 2nd) and her prenatal care was considered good. During her seventh month, she developed ankle edema, chest pain, and was admitted November 23rd to the first hospital. Cardiological consultation reported "25 per cent heart enlargement by x-ray. Believe patient should tolerate pregnancy well and can be delivered vaginally." She was discharged, improved, November 24th.

Labor began spontaneously 8:30 a. m. January 13th (at 37 weeks) and the patient was admitted the second time (first hospital). Her course in labor was progressive; medication included demerol,® scopolamine and nembutal.® After a 24 hour labor the patient was delivered by forceps, over a median episiotomy, living baby, without complication. Her hemoglobin was 16 grams, white blood count 14,550, urine 200 mg. of albumin. The nurses' notes indicated cyanosis of the fingers, and slight chest pain. Otherwise her postpartum course was uneventful, and she left the hospital with her baby on January 19th.

Her third hospital admission occurred February 13th (second hospital) because of dyspnea, cyanosis (one week), pain in her chest, and symptoms of a "cold." Examination revealed cyanosis and acute respiratory distress, blood pressure 110/65, pulse 120, respirations 24, temperature 102.4°. Mucous membranes were inflamed, lungs hyperresonant, heart showed palpitation and a gallop rhythm, no murmurs. Treatment consisted of antibiotics, digalen,® oxygen, and sedatives. In spite of therapy, the patient's condition deteriorated and she finally died February 15th. Autopsy permission was obtained.

Pathological Diagnosis: Congestive heart failure; passive congestion of lungs, spleen and kidneys; massive pulmonary edema; congenital heart disease with intraventricular septal defect, status postpartum one month.

COMMENT

The Committee reviewed the facts of this case with a great deal of interest and noted that the report was quite complete in presenting details of the case. The cardiac consultant apparently was well qualified, and quite honest in his evaluation of the case (first admission); however it was felt that he should have indicated the necessity of closer subsequent follow-up examinations thereafter. It was also felt that he should have seen the patient for evaluation during her postpartum course, when the patient developed cyanosis and chest pain (noted by the nurse). On the basis of a lack of continued expert observation and special care which these patients require, the Committee voted the case a preventable death.

COMMENT OF CONSULTANT

The following comment of a consultant, who is a specialist in cardiology, was given at the request of the Committee.

Pregnancy imposes a definitely greater risk to the cardiac than the non-cardiac patient, and the obviously decompensated patient should avoid pregnancy. On the other hand, with proper management the well compensated cardiac should tolerate pregnancy without significant additional risk. The circulatory load due to pregnancy increases to a maximum at about the eighth lunar month, and then decreases as term is approached. Normal labor is relatively well tolerated, with initial failure rarely occurring during or immediately after delivery. However, if failure is present when labor begins, there is great risk of further decompensation, especially in the first few days postpartum.

The cases reported here are unusual in that all three had congenital heart disease, which is encountered in only 1.5 to 5 per cent of pregnant cardiac patients, in contrast with rheumatic heart disease which occurs in over 90 per cent.

Case 49. From the information presented, it would appear that this was a preventable death.

This is in disagreement with the conclusions of the Committee. The patient had tolerated a pregnancy in the previous year without difficulty, and began to decompensate only with the maximum circulatory load. This may have been avoidable.

Four visits to the physician during the last half of pregnancy is hardly consistent with adequate prenatal care for a patient with heart disease, who should be followed closely, with more frequent visits than the non-cardiac, especially as the maximum circulatory load is approached. Such a patient should avoid overexertion and excessive sodium intake, and acute infections should be treated promptly, since these may precipitate failure. Arrhythmias, excessive anemia and evidence of excessive water retention should be corrected. If incipient failure is discovered, treatment should be instituted immediately.

Even after failure was evident, her management may not have been adequate. She was apparently not well compensated when discharged from the hospital on May 7, since the ventricular rate in the presence of atrial fibrillation is usually reduced below 100 by adequate digitalization. Since the atrial fibrillation was of recent onset, it is likely that reversion to sinus rhythm would have occurred with proper management. Quinidine may be used without additional risk because of pregnancy, if an arrhythmia persists in spite of maximum alleviation of failure. The treatment of decompensation should include not only full digitalization and rest, but also a rigid restriction of sodium intake, and the use of diuretics.

The use of low forceps to avoid a prolonged second stage is commendable. The competent administration of anesthesia with maximal concentrations of oxygen is important. Ergotrate® should not be used. Pitocin® (**not** pituitrin®) may be given, intramuscularly, only if necessary. It should be pointed out that a moderate blood loss may be beneficial in reducing the excessive blood volume of a patient with heart failure. The application of tourniquets during the third stage of labor may be helpful. Intravenous fluids should be avoided or used with great caution, and should not contain sodium. Morphine should be given promptly in case of acute pulmonary edema.

Case 25. Although the patient undoubtedly should have sought prenatal care at an early date, her death might still not have been preventable. In spite of hemorrhage her hematocrit was 56 per cent, which suggests high resistance to pulmonary blood flow and at least partial reversal of the left-to-right shunt through the interatrial septal defect. This probably came about as a result of the natural course of this defect, or possibly from previous multiple small pulmonary emboli. (Even in the absence of primary heart disease, repeated small emboli may occur and be unrecognized, especially postpartum.)

The immediate postoperative course of this patient was apparently satisfactory until the third day, when fatal pulmonary embolization occurred. Myocardial infarction of the right atrium is extremely uncommon, and probably was on an embolic basis, the embolus reaching the systemic circuit through the septal defect (paradoxical embolization).

The prevention of thromboembolic phenomena depends upon the elimination, when possible, of predisposing factors, use of anticoagulants, and early ambulation.

Case 84. It is difficult to understand why this patient, who tolerated the increased circulatory load of pregnancy and labor fairly well, should develop severe congestive heart failure several weeks postpartum. It would help to have additional information. The repeated chest pain is suggestive of pulmonary emboli, as in the previous case. Infection might also have been a factor in precipitating failure. Neither of these are mentioned in the pathological diagnosis. It is unfortunate that she did not receive closer observation.

By way of a reminder, all patients with rheumatic or congential heart disease should be given antibiotics (e. g., penicillin and streptomycin) for the prevention of subacute bacterial endocarditis due to bacteremia during delivery.

Controlled Passenger Deceleration In the Automobile

In the car that you have now, what will the seat belt do? First of all, it will keep one in the car. This alone doubles the chance of survival. The idea that one is safer to be "thrown clear," as the saying is, is not borne out by careful investigation.

Next, it will reduce the severity of head injury. It will not always prevent head injury but it will reduce the energy of the blow. This has been proved beyond all doubt in a study by Cornell of 1,039 survivors of light plane crashes, 39 of whom had forgotten to fasten their belts. Head injury was present in 32.8 per cent of the 1,000 belted survivors, and in 84.6 per cent of the nonbelted. Dangerous head injury was present in 15.3 per cent of the 1,000, and in 41 per cent of the 39.

And, finally, the belt will not "cut one in two," as you may have heard. Only nine out of the 1,000 belted survivors had severe injuries due to the belt and this in spite of the fact that 221 persons actually broke their belts.

Some may hesitate to translate aeroplane crash experience into motorcar expectancy. Fortunately, enough people have felt that it was logical to do this that we have an increasing series of automobile crashes with belts.—Horace E. Campbell, M. D., Denver, Colo.: *Nebraska State M. J.*, 42: 155-158, April, 1957.

The Coombs Test*

THE Coombs test or antiglobulin test is a sensitive method of demonstrating any antibody capable of being adsorbed on red blood cells. It is especially of value in the demonstration of the antibody of acquired hemolytic anemia. The Coombs test is also of great value in cross-matching procedures. It has averted many potential transfusion accidents by demonstrating the presence of adsorbed antibody.

The Coombs or anti–gamma globulin serum may be prepared by injecting human gamma globulin into rabbits and thus producing an anti–human gamma globulin. Actually whole human serum is injected into rabbits and the resultant anti–human serum obtained from the sensitized rabbits is absorbed with mixed human red cells to remove all the usual antibodies and leave essentially an anti–human gamma globulin.

Essentially the Coombs or antiglobulin test is performed by mixing red blood cells with Coombs serum. There will be clumping of red cells only if an antibody is "coating" these red cells. The Coombs test may be done as a direct test or as an indirect test. The direct test is done by directly exposing the patient's cells to the testing Coombs reagent. A positive reaction indicates sensitization of the cells. An indirect Coombs test is usually done upon the serum of a potential donor for transfusion. The donor serum is mixed with the red blood cells of the recipient. Then these presumably normal cells are tested with the Coombs reagent to see whether they have been coated by incompatible antibodies.

A positive Coombs test, in a patient with hemolytic anemia, is usually pathognomonic of the acquired type. In the congenital hemolytic anemia, the red cells or their hemoglobins are at fault and the Coombs test is negative because there are no circulating antibodies in the serum of these patients. The most familiar of the congenital group is congenital hemolytic icterus (hereditary spherocytosis), an entity usually cured by splenectomy. A negative Coombs test, therefore, in a case of hemolytic anemia is of extreme importance before splenectomy. In none of the large group of hemolytic anemias associated with congenital hemoglobin abnormalities is the Coombs test positive.

*Those desiring reprints of this article may secure them by writing to the Ohio Society of Pathologists, 267 E. Broad Street, Columbus 15, Ohio.

Submitted February 22, 1957.

The Author

● Prepared for the information of all Ohio physicians by the Ohio Society of Pathologists.

The acquired hemolytic anemias are often characterized by peculiar antibodies in the serum; antibodies which coat or adsorb onto otherwise normal red cells and render these cells incapable of surviving their expected 120 days. These autoantibodies are readily demonstrable by the positive Coombs test. The idiopathic acquired hemolytic anemia, the acquired hemolytic anemias secondary to leukemia, lymphosarcoma, disseminated lupus erythematosus, and thrombotic thrombocytopenic purpura (Moschcowitz's disease), all show this peculiar antibody and respond with a positive Coombs test. Similarly the hemolytic anemia following virus pneumonia and paroxysmal cold hemoglobinuria reveal a positive Coombs test although the antibodies here may show other peculiarities. Erythroblastosis fetalis or hemolytic disease of the newborn will give positive Coombs tests in the group of Rh incompatibilities and often in the ABO incompatible matings.

There are some acquired hemolytic anemias in which the Coombs test is negative. These are the hemolytic anemias of hypersplenism, of sulfonamide sensitization, blackwater fever, septicemia, severe burns, and uremia. In none of these is there any serologic change to be found. The hemolysis in most of this group is probably due to damage or derangement of the red cell rather than in changes of the serum proteins. Paroxysmal noctural hemoglobinuria is an acquired hemolytic anemia with a negative Coombs test, but here the red cells have definitely been proved abnormal.

The explanation of the theory of the Coombs test procedure may possibly have been presented too simply but the Coombs test unquestionably is a very valuable tool in the diagnosis of hemolytic anemias, and in the management of transfusions.

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Proceedings of the Ohio Society of Pathologists

Reported by PAUL N. JOLLY, M.D., Cincinnati, Ohio

THE fall meeting of the Ohio Society of Pathologists was called to order on the afternoon of September 22, 1956, by Dr. Paul Wozencraft. Four papers were presented in the Scientific Meeting.

SCIENTIFIC PROGRAM

Dr. Boris Gueft's topic was "Estrogen Influenced Lymphocyte of the Guinea Pig." This cell, previously identified as a lymphocyte, is probably a histiocyte. It was first described in 1889 and is characterized by an eosinophilic cytoplasmic inclusion which frequently distorts the nucleus. No internal structure in the inclusion can be resolved, even by the use of electron microscopy. Although present in small numbers in both male and female guinea pigs, it reaches its highest levels, up to 40 per cent of the white cells, in the pregnant female. No similar cell has been identified in any other animal species.

An increase in the number of these cells has been produced not only by pregnancy but following the administration of estrogenic hormones or the injection of human pregnant urine. In an attempt to clarify the relation to estrogenic hormones, one series of animals was administered estrone, while the control group received saline. In both groups there was an increase in the percentage of the inclusion containing cells. The greater increase on the estrone series was not statistically significant in view of the small size of the groups.

Special studies were done in an attempt to identify the nature of the inclusion. It stained intensely with osmic acid, gave a positive PAS reaction and produced metachromasia with toluidine blue. It did not contain nucleotidase, acid phosphatase, arginine, sulphydryl, tryptophane or tyrosine. The spectral absorption curve with a broad peak at 2600 A° and a sharp peak at 4000 A° is unlike any estrogen or its precursors.

The work of Dr. C. J. Kao and Dr. Jan Schwarz on "The Isolation of *Cryptococcus neoformans* from Pigeon Droppings," was presented by the latter. In an attempt to identify a carrier of *Histoplasma capsulatum*, 107 pigeon nests collected within a radius of 20 miles from Cincinnati were studied. Three to five grams of the droppings of each nest were pulverized, suspended and fractions injected into mice intraperitoneally. Of the 107 nests, 43 contained *Cryptococcus neoformans*, an encapsulated pathogenic yeast which grows at 37°C, and which is lethal for mice. A detailed study of 19 of the 43 strains revealed some variations in pathogenicity and marked variations in cultural morphology.

Submitted February 26, 1957.

Dr. Schwarz feels that the temperature requirements for growth offer the quickest means of identifying the pathogenic strains. In mice, regardless of the route of administration, a meningitis is generally present. Toxicity is probably responsible for death, for in many instances organisms are identified with difficulty, even using the mucicarmine stain. In the discussion which followed, Dr. Schwarz stated that the fungus has not been isolated from tissues, alimentary contents or fresh feces of any of the pigeons examined to date. Pathogenicity of the *Cryptococcus* for pigeons is now being investigated.

IDIOPATHIC INFANTILE CARDIOMEGALY

Dr. B. Black-Schaffer spoke on "Idiopathic Infantile Cardiomegaly—A Suggested Etiology." He feels that endocardial fibroelastosis is the result and not the cause of myocardial hyperplasia. The problem of hyperplasia vs. hypertrophy was studied by the use of nuclear density. He found in most hearts that the number of nuclei per unit volume decreased as the weight of the heart increased, that the nuclear density multiplied by the heart weight gave a constant and that the curve produced was an hyperbola.

The hyperplastic hearts studied had twice as many nuclei as other hearts and presumably were the result of an extra cell division. Two or more supernumerary divisions are probably incompatible with life. Such a hyperplastic myocardium has an increased number of fibers of smaller size. Since the greatest isometric tension of a myocardial fiber is produced at resting length (diastolic length), a myocardium composed of smaller than normal fibers would seem to be a weaker myocardium.

The increased area presented by such fibers causes an increase in "friction" and interfascicular tension, therefore a waste of energy and decreased myocardial efficiency. Such a left ventricle would dilate considerably more than normal when presented with the increased burden of the postnatal circulation. While the dilatation may increase the strength of systole at the same time it subjects the fibers to an increased tension proportional to the cube of the ventricular radius (considering the ventricle a sphere), the combination of these factors leads to a series of dilatations and hypertrophies.

THE EFFECTS OF SUBDURAL EFFUSIONS ON THE BRAIN IN INFANCY

"The Effects of Subdural Effusions on the Brain in Infancy," was the subject of Dr. Joseph F. Smith's paper. Three cases were presented.

A 7 month infant developed a postinfluenzal subdural effusion. Failure of response to re-

peated aspirations necessitated craniotomies with removal of the membranes at 30 and 60 days. The postmortem brain exhibited shrunken frontal lobes, thickened basal leptomeninges, gliosis, a laminar necrosis of the cortex and a perivenous infiltration of lymphocytes and monocytes.

A 16 month infant died of a respiratory infection. Although "fits" had been occurring since birth, no neurologic examination had been done. Large bilateral subdural hematomata were present. The brain was shrunken and hippocampal herniation was marked. Demyelinization of the white matter was marked and glial fibers were increased in number.

A chronic pneumococcal meningitis started at the age of six months and terminated in death at 12 months. Autopsy revealed a subdural effusion, acute and chronic meningitis, arteritis with focal thrombosis and marked focal brain necrosis.

Dr. Smith postulates that the pressure of any type of effusion, infectious or traumatic, produces in turn venous compression, cerebral hypoxia and cerebral edema which terminate in brain damage. Therapy should then be directed at decompression, either by aspiration or surgical drainage of the fluid. He feels that an elucidation of the pathogenesis is important in view of the fact that the infectious subdural effusions now have such a good prognosis in terms of mortality but such a poor prognosis in terms of morbidity.

* * *

Abstracts of Cases from Slide Library

The slide library was moderated by Dr. Edward A. Gall, Professor of Pathology, University of Cincinnati. The diagnoses represent the concensus of the group.

Case 594: Submitted by Dr. D. Freiman, Beth Israel Hospital, Boston, Massachusetts. Presented by Dr. J. Smith, Cincinnati General Hospital, Cincinnati, Ohio.

A 26 year old white man was admitted to the hospital with dull aching lower back discomfort of seven months duration. He had had an episode of low back pain at the age of 15, and again at the age of 18, but had been otherwise well and able to engage in active sports. A mass visualized by myelography in the sacral canal proved to be a fairly well encapsulated tumor adherent to the dura and nerve roots from L5 to S3. There was pressure erosion of the posterior wall of the sacral body. The mass was partially resected and intense x-ray therapy instituted. Severe symptoms recurred two years later, characterized by increasing pain, weight loss, and urinary and bowel dysfunction. An operation at this time revealed enlargement of the tumor. Rapid progression with extension of tumor to the tissues of the back ensued, and the patient failed rapidly and expired.

Microscopic: The slide showed large and small nests of rather uniform polyhedral cells infiltrating a cirrhotic liver. The cells showed some tendency to form perivascular groups and pseudorosettes. No glands were present.

Diagnosis: Metastatic ependymoma.

Case 595: Presented by Dr. Hal Conlon, Luther Hospital, Eau Claire, Wisconsin.

An 89 year old white woman complained of sudden onset of severe pain in the upper abdomen. This was associated with nausea and vomiting. She had been known to have stones in the gallbladder for several years, but because of a poor cardiac status, surgery was not considered. The past history was otherwise negative, and she was not known to have any chronic disease until the onset of arteriosclerotic heart disease. She expired on the third hospital day and showed general peritonitis secondary to empyema of the gallbladder with perforation. The liver was large with striking reddish-brown mottling. No abnormalities of the extrahepatic vasculature or common duct were noted.

Microscopic: The liver was perforated by numerous blood filled spaces of varying size. Between these the liver cells were frequently compressed and distorted. No endothelial lining could be seen in most of these spaces.

Diagnosis: Peliosis hepatis.

Case 596: Submitted by Dr. W. Collins, Grand Rapids, Michigan. Presented by Dr. E. A. Gall, Cincinnati General Hospital, Cincinnati, Ohio.

A 77 year old man was hospitalized in January 1956 with choking sensation. A rectal carcinoma had been resected in February 1951. Physical examination showed evidences of mild congestive failure. A few hours after admission the patient became comatose with areflexia and flaccidity of all extremities. The pupils were constricted and Babinski sign was present bilaterally. Fasting blood sugar was 45 mg. per 100 cc. and blood urea nitrogen was 18 mg. per 100 cc. He expired 30 hours after admission. The significant autopsy findings were a 330 gram spleen containing numerous, soft, hemorrhagic foci beneath the capsule; a 3,220 gram liver which was friable, red and diffusely involved with dilated vascular channels, some of which contained thrombi; and several enlarged, periaortic lymph nodes with foci similar to the liver. The brain was essentially negative.

Microscopic: Infiltrating the liver were large and small blood filled spaces. The cells lining these spaces were large, pleomorphic, and occasionally formed large masses projecting into the lumen. Mitoses were present.

Diagnosis: Diffuse angiosarcoma.

Case 597: Presented by Dr. Boris Gueft, U. S. Veterans Hospital, Cincinnati, Ohio.

A 57 year old silver solderer was admitted on February 10, 1955. One year ago he noted weakness and fatigability. During recent months there were anorexia, weight loss (50 pounds), mild productive cough, night sweats and upper abdominal aching. Temperature 101.8°; pulse 88; respirations 24. The liver and spleen each extended 8 cm. beneath the costal margin. Blood counts revealed anemia, leukopenia and diminished platelets. Culture of liver biopsy which showed miliary granulomas yielded a peculiar acid fast bacillus which appeared nonpathogenic for hamsters and guinea pigs. Treatment with streptomycin and isoniazid for several months gave no benefits. A month before death he developed evidence of right lower lobar pneumonia, and sputum contained organisms similar to those isolated from the liver. He entered in poor condition and died eight months after entry.

Microscopic: Small granulomata and diffuse inflammation were present throughout the liver.

Acid fast stains showed the presence of numerous small acid fast rods in these granulomata and in the Kupffer cells. Cultural characteristics indicated that they were Nocardia intracellularis. In some of the slides there were also occasional colonies of Candida.

Diagnosis: Nocardia intracellularis infection.

Case 598: Presented by Dr. Joseph Smith, Cincinnati General Hospital, Cincinnati, Ohio.

A 43 year old man was hospitalized because of weakness. In November, 1953, a diagnosis of lymphosarcoma had been made on a cervical lymph node biopsy. He responded to roentgen therapy from April to October, 1954. In October, 1954, he entered a hospital with increasing weakness.

Physical examination revealed blood pressure 110/50, pulse 120, temperature 101°. There were enlarged, matted, cervical lymph nodes, fundal hemorrhages, hepatosplenomegaly and purpura over the lower extremities. Red blood cell count was 1,000,000, hemoglobin 3 Gm. per 100 cc. and white blood cells 1,150 with 62 per cent neutrophiles. There was no evidence of lymphoma replacing the bone marrow. He received 9 units of blood and left the hospital only to be readmitted four days later with deep jaundice. This time the urine had 2 plus albumin, a few red blood cells, white blood cells and granular casts. Direct Coombs test was positive. Blood transfusion, antibiotics, hydrocortisone, irrigation and nitrogen mustard were administered.

Final admission was on January 18, 1955. There was a continuous frontal headache. His course was febrile with temperature up to 104°. Confusion and blindness of the left eye were noted on January 28th. Fundi were normal, confusion deepened, and he developed gross tremors. Babinski reflex was positive. He lapsed into deep coma and died on February 7, 1955.

Microscopic: The section demonstrated an acute and chronic leptomeningitis and encephalomyelitis. Fungi, isolated and in colonies, were identified in the subarachnoid space and in and about the blood vessels. The large branching hyphae looked like pale acidophilic tubules in the sections. On the basis of the morphology of the hyphae they were thought to belong to the genus Mucor. Cultural proof of the identification was not possible. All available tissue had been fixed before the lesions were identified.

Diagnosis: Mucormycosis.

Case 599: Presented by Dr. Edward A. Gall, Cincinnati General Hospital, Cincinnati, Ohio.

A 49 year old housewife was admitted to the hospital on February 7, 1956, in a convulsion. She was first admitted in 1935 for a normal childbirth and at that time her physical examination was normal. She entered the clinic in 1945 with an 18 month history of blanching and numbness of the hands on exposure to cold. Physical examination: blood pressure 110/60; pulse 72. The skin of the face and fingers was pale, smooth, shiny and stretched tightly over the subcutaneous tissues. Roentgenograms of the hand showed mild, generalized decalcification. Scleroderma was diagnosed on a skin biopsy. Contractures of interphalangeal joints with alteration of fingertips appeared over the years. In January 1956 she complained of blurred vision and severe headaches. In February 1956 she became disoriented, vomited and had tonic and clonic seizures. Blood pressure 220/120. Fresh hemorrhages were noted in the fundi. Facial skin was taut, giving a fish-mouth appearance to the lips. There were rhonchi in the lungs. Urine had 4 plus albumin, 1 plus sugar, and negative acetone. Blood urea nitrogen 47 mg. per 100 cc. Fasting blood sugar 166 mg. per 100 cc. CO_2 combining power 19 volumes per cent. *p*H 7.2. Lumbar puncture showed spinal fluid with 290 mg. protein and 93 mg. sugar. Blood pressure remained elevated and coma persisted in spite of treatment. She expired a few days after admission.

Microscopic: Most of the larger renal arteries, and especially the interlobular arteries, showed a marked degree of endothelial proliferation which occasionally obliterated the lumen. A necrotizing arteriolitis was present and caused segmental infarcts in some of the glomerular loops.

Diagnosis: Scleroderma kidney with accelerated arteriolar nephrosclerosis.

Case 600: Presented by Dr. Benjamin Landing, Cincinnati Children's Hospital, Cincinnati, Ohio.

A white infant was born after a difficult, 30 hour labor. The difficulty was due to dystocia caused by inability to flex the infant's head on the neck as the result of a large mass in the neck. The patient was referred to Children's Hospital at age 9 hours. Physical examination showed a lobulated, cystic mass measuring 9 by 6 by 5.5 cm. occupying the anterior neck from the submandibular region down. Removal was performed on the day of admission.

Microscopic: The multiple cysts within the mass showed varying types of linings. Squamous epithelium was of the mucosal or cutaneous type. Glandular epithelium was representative of many sources in the gastroenteric and respiratory systems. Among the tissues identified in the stroma were fibrous connective tissue, cartilage, smooth muscle, peripheral nerves and brain tissue.

Diagnosis: Benign teratoma.

Case 601: Presented by Dr. Paul Wozencraft, Cincinnati General Hospital, Cincinnati, Ohio.

A 22 year old Negro woman was admitted on April 9, 1956, with complaint of an enlarging suprasternal mass. Two months prior to admission the patient noted that the soft, previously asymptomatic cystic mass anterior to the manubrium began to grow and intermittently drain a thick, white material. There was a 4 by 6 cm., soft, movable, cystic mass lying beneath the skin and anterior to the manubrium. It was separable from the suprasternal notch. The center of the mass was black and had purplish appearing spots. On April 12, 1956, the mass which proved to be cystic was excised.

Microscopic: The wall of the cyst showed the structure of a bronchus with a ciliated columnar cell mucosa, a thick red basement membrane, a loose fibrous submucosa containing mixed serous and mucous glands, and occasional small bundles of smooth muscle.

Diagnosis: Bronchogenic cyst.

Case 602: Presented by Dr. Paul Wozencraft, Cincinnati General Hospital, Cincinnati, Ohio.

A 51 year old, white man was admitted to the hospital May 7, 1956, with complaint of a small lump in his left parotid gland. About one and a half years prior to admission he noted a small nonpainful lump in his left parotid. Nine months prior to admission the mass began to grow. He consulted a surgeon who advised excision. Two months prior to admission the surgeon saw him again and noted considerable growth since Janu-

ary 1956. On examination there was a 4 by 5 cm., firm, movable, nontender mass over the left parotid. On May 8, 1956, the mass was excised.

Microscopic: The normal gland was replaced by a tumor showing various characteristics. Parts were similar to the acinic cell tumor (cf. OSP slide 532) with masses of large cells with abundant pale or vacuolated cytoplasm. Large sheets of small cells were solid or perforated by numerous small lumens. The cytoplasm was scanty and dark while the nuclei were relatively large, pleomorphic and polychromatic. The stroma contained a dense lymphocytic infiltration with focal follicle formation.

Diagnosis: Adenocarcinoma — multiple patterns.

Case 603: Presented by Dr. Paul Jolly, Christ Hospital, Cincinnati, Ohio.

A 61 year old white woman had a lump in the upper outer quadrant of the breast for six years. The lump had grown slowly during this time. The excised mass was 4.5 by 3 by 2.5 cm. It had a uniform tan cut surface. The peripheral margins were sharply defined, and no extension into the surrounding fat was found.

Microscopic: The tumor was composed of regular small polyhedral cells arranged in nests. Some were solid while others contained cystic spaces of varying size. In spite of the gross appearance, there was extension of the tumor into the surrounding fat and through some adjacent ducts. Morphologically the tumor is similar to that arising in nasal and oral glands and in the sweat glands.

Diagnosis: Adenoid cystic carcinoma.

Case 604: Presented by Dr. Benjamin Landing, Children's Hospital, Cincinnati, Ohio.

A 16 month old white boy was admitted for the first time because of anaphylactoid purpura and angioneurotic edema of the genitalia. He was treated with benadryl.® After five months the purpura recurred, and he was treated with cortisone. He had several subsequent admissions because of exacerbation of symptoms, each episode following a respiratory tract infection. By two years after the onset of the disease he had developed hepatosplenomegaly and persistent anemia with low normal platelet and white counts. A splenectomy was performed on March 20, 1956.

Microscopic: Histologically the enlarged spleen showed nodular, grape-like scars which were concentrated around some of the trabeculae. The fibrous stroma was dense around the periphery and loose centrally. A sparse nonspecific infiltration of lymphocytes and macrophages was present. The case was presented as a diagnostic problem and the descriptive diagnosis, although representing the opinion of the majority of those voting, was not enthusiastically supported.

Diagnosis: Idiopathic micronodular splenopathy.

Lung Function in Emphysema

In pulmonary emphysema, depending upon the severity of the disease, vital capacity, one second vital capacity and maximum breathing capacity are also decreased. The residual volume is increased. With the use of bronchodilators (epinephrine injection, inhalation of isuprel®) there is little or no change in these lung function determinations.—William Appel, M. D., Kalamazoo: *J. Michigan M. Soc.*, 56:213, February, 1957.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Serpiginous—This term is descriptively applied to skin lesions that are of a creeping nature or have an irregular or serpentine shape. The term comes from the Latin word "serpere," meaning "to creep."

Teres—A Latin word, meaning "smooth, rounded off, or round," which was generally applied to smooth, round or cylindrical objects. Anatomically the term was descriptively applied to several ligaments and muscles which were probably so named in about 1700 by William Cowper, an English anatomist. These structures are the ligamentum teres, or the round ligament of the head of the femur and the Teres Major and the Teres Minor Muscles.

Thorax—The Greek word "thorakos" originally designated a breast-plate or cuirass and by transferance the term came to mean that part of the body which is covered by a breast-plate. The term is of ancient usage and Hippocrates used it to designate the chest. The word made its appearance in English some time in the fourteenth century.

Thumb—This word comes from the Middle English word "thoumbe" and is related to the German "daumen," the Dutch "duim," the Swedish "tumme" and the Welsh "tump"—all meaning "thumb." These words all stem from a common root, meaning "a mass, heap or swelling." Hence the term thumb literally designates the short, thick or swollen finger. At first the term referred to either the first finger or toe and only later came to be restricted to the first finger.

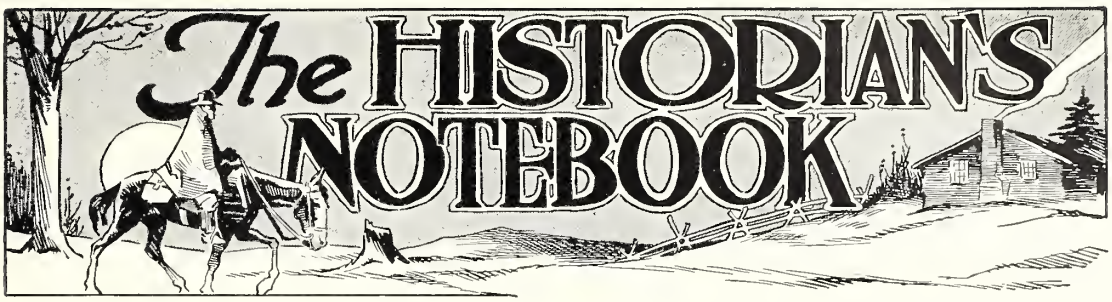
Thyroid Gland—This gland was so called because it rests upon the shield-shaped thyroid cartilage. The gland itself bears no resemblance to a shield and was at first known as the laryngeal gland. Thomas Wharton in 1646 called it the thyroid gland.

Tolu—This word is short for the earlier term "Balsam of Tolu." This balsam is obtained by cutting into the bark of the tolu tree which grows in tropical South America. The term is said to come from a place called Tolu, which is now known as Santiago de Tolu, in Bolivia. Balsam of Tolu was famous in England as early as 1673.

Tophus—A term applied to any mineral concretion in the body. Tophi are usually found around the joints and are especially common in cases of gout. Tophus is a Latin word coming from the similar Greek word "tofus," which denoted a loose porous type of stone.

Torpor—A Latin word, meaning "numbness," which is now used to denote sluggishness or inactivity. It comes from the Latin "torpere," meaning "to be still or to be stiff with frost."

—Harry Wain, M. D., Mansfield, Ohio.



The Ohio State School One Hundred Years Old

JONATHAN FORMAN, M. D.

THE Ohio State School is celebrating its 100th year of existence this summer. A Special Citizen Committee with the help of The Ohio Association of Retarded Children and The Parent's Volunteer Association of the school are cooperating to put on a celebration big enough to awaken the people of Ohio to their full responsibility in the education or training of 43,770 of their children who are in need of special help. It is hoped, too, that the minds of Ohio's citizens may be cleared of false ideas about mental retardation. For instance, that it is the same as mental illness; that it is inherited; that such children are different from other children; that it is a hopeless condition for which nothing can be done.

As the public has become aware of the truth, the names applied to the unusual children have changed from idiot and imbecile, to idiot and moron, to the retarded child, and some now speak of them as the unusual child. While these names represent more the wearing out of overused words, still they suggest a growing realization that the unfortunate youngsters are not hopeless but are worthy of training in all instances and of education in more than half of the cases.

OHIO STATISTICS ON RETARDED CHILDREN OF SCHOOL AGE

Of the school age population 3% are retarded to some degree	43,770
a. Educable (slow learners)	36,475
b. The trainable eligible of State and County classes	5,836
c. Those eligible for custodial care only	1,459
Total	43,770

In the 100 years of concern on the part of the State of Ohio about her retarded children, we still find 55,806 children of school age, of whom many are undoubtedly retarded, not enrolled in any school.

The history of society's concern with the training of idiots extends back into the Middle Ages in vague and legendary forms. Teachers and physicians about 1800 began to study retarded individuals and to train them; so that by 1839 Dr. J. Guggenbuehl had studied cretinism and M. Saegert had opened a school in Berlin. In 1846 Dr. Kern had established another school in Leipsig and another one had been set up at Bath in England.

In Ohio in 1840 little was known about idiocy. Norton Townsend, M. D., who was to be responsible for the founding of the Ohio State University some 35 years later, had investigated some of these attempts to educate idiots while on a trip to Europe. Others like Dr. William Awl, the physician to and superintendent of the Franklin County Poor House, had observed those retarded persons who had come to live there and evidently thought that not all of these were hopeless. But most people looked upon them as a disgrace in the families of others, while an idiot in their own family was an object of embarrassment and shame, demanding and receiving as the retarded child always has, greater love and affection from his parents than his normal brothers and sisters. If he were seriously retarded, he was considered a hopeless case and was kept hidden as an invalid or as a prisoner, finally to end up in the county home upon the death of his parents. If, on the other hand, he was considered only "dull," he usually was allowed to shift for himself, ignored except when through the lack of training he hurt or endangered society. Then he would be confined as a criminal.

Sociological words wear out as they take on fixed and unpleasant connotations. *Idiot* and *imbecile* become *idiot* and *moron*, then *feeble-minded*, and nowadays *the retarded child* and over the horizon even now comes *the unusual child.*

DR. WILLIAM AWL

By 1844, Dr. William Awl who had successfully steered the proper legislation resulting in the founding of the Ohio Lunatic Asylum at Wash-

Submitted March 4, 1957.

ington Avenue and East Broad Street, suggested to the meeting of the Superintendents of Lunatic Asylum meeting in Philadelphia that something ought to be done about the education or at least the training of our idiots and imbeciles. Dr. Norton Townsend was serving in the State Senate and Dr. Hanbury Smith, close friend of Daniel Drake, who had been responsible for The School for the Blind and later to finish Drake's Opus Magnum and see through the press the second volume of *The Disease of the Valley of North America*, was convinced of the need of attacking the problem of mental deficiency. These three physicians—Townsend, Awl, and Hanbury Smith—went to work to get a school for the idiot and the imbecile. In this they were joined by Dr. R. J. Paterson who later became the school's first superintendent.

Others were thinking about the same time. In 1846, Massachusetts opened an experimental school following the founding of a private school by Dr. H. B. Wilbur at Barre, Massachusetts. Dr. Wilbur was later called to New York to head an experimental school at Albany in 1851. New York's permanent school was established at Syracuse in 1854. In Pennsylvania, Dr. J. B. Richards founded a private school at Germantown, which later was taken over by the state and moved to Media to become the Pennsylvania State Training School for Idiots. Connecticut followed suit in 1855.

THE ENABLING ACT

Drs. Awl, Hanbury Smith, Townsend, and Patterson carried the ball in the Ohio legislature unsuccessfully from 1850 until the winter of 1856. It was not until they brought Dr. H. B. Wilbur from the New York School with two of his students that they made any real headway. When the members of the Ohio General Assembly witnessed a demonstration of what Dr. Wilbur had been able to do with these two students, the legislators were impressed. Herman Canfield was inspired to introduce a new bill. It passed the Senate 28 to 2 and the House on April 17, 1857, by a vote of 60 to 14.

It was estimated by the authorities in 1858 that there were some 2,000 imbeciles and idiots in the state and that one-fourth of them were eligible for training. The Ohio Asylum for the Education of Idiotic and Imbecilic Youth was promptly opened in a leased house on Friends Street in Columbus, Ohio, (now Main Street) and soon became overcrowded. In 1865 the present site was purchased and buildings were planned and foundations laid. From 1857 until 1864—until the present site was purchased and occupied—the history of the institution was literally a fight against discontinuance on the one hand and a struggle for the enlightenment and education of the people outside of the General Assembly as to the urgent necessity of the school for their own benefit on sociological and economic grounds alone as well as the benefit of the feeble-minded, as a class, on grounds of humanity.

By 1865, it became apparent that there was no place for adult patients who were past the age of 15 and no longer trainable. It took until April 22, 1898, to get a law providing for the custodial care for the "feeble-minded." About this same time the name of the institution was changed to The Ohio Institution for Feeble-Minded Youth.

ORIENT SCHOOL

There was purchased a tract of land (1068.35) near Orient, Ohio. Here a farm colony was set up for the custodial care of the older patients and the production of food for all the students. From 1907 on, the story is one of progress with better faculties for academic education and vocational training, more research into the causes and more interest on the part of the public. In February 1952, the Volunteer Service Committee (the first of its kind in any institution for the mentally retarded) was formed to co-ordinate the offers of assistance from the community. Through the offices of this Department (now known as Special Services Department) a Parent's Volunteer Association comparable to P.T.A. was organized which works closely with the school. In 1945, the name of the institution was changed to The Ohio State School.

While there remains much to be done for an ever increasing number of the retarded (a fixed percentage of the total population), Ohio can be proud of the program not only of custodial care for the many but even more for the broad training program of academic instruction, occupational training, religious education, and research. All of this is designed to develop each boy and girl to the fullest of their capacity and so make them less of a burden on society and their lives more pleasant.

Bronchodilator Drugs—A Comparison In Emphysematous Patients

1. In the emphysematous patients reported in this study an increase in vital capacity and maximum breathing capacity occurred in most cases following the administration of the usual bronchodilator drugs.

2. The response occurred regardless of the drug administered or the route of administration.

3. From the point of view of rapidity of action and duration of response intravenous aminophylline appeared to be the most effective of the drugs studied.

4. Of the oral bronchodilator drugs, ephedrine gave a better response than orthoxine but was more apt to produce unpleasant side effects.

5. The sublingual tablet Win 3046-B produced a good bronchodilating response which came on rapidly but was of short duration.—Burnet W. Peden, M. D., and Herbert C. Sweet, M. D., St. Louis: *Missouri Med.*, 54:333-336, April, 1957.

Medicare Interpretations . . .

Clarifying Memoranda Issued by Washington Office on Matters Relating To Maternity Cases and Procedures Pertaining to Emotional Disorders

AMONG clarifying memoranda recently issued by the Office of Dependents' Medical Care, Washington, D. C., for the information of administrators and physicians was one pertaining to maternity cases and another relating to acute emotional disorders.

Following are excerpts from the memorandum on maternity cases:

The Medicare Program became effective on December 7, 1956, and maternity care rendered prior to this date is not an obligation of the Government. Similarly, care rendered to a patient before her sponsor became an active-duty member of the uniformed services, or that rendered after his separation from active duty is not an obligation of the Government.

A physician rendering normal ante-partum care may be considered to have rendered full care for the fractional period concerned if he sees the patient even one time in this period. (This refers to key periods "a," "b," "c," etc., on scale.) A physician, in rendering "normal" ante-partum care according to his customary practice, may see a patient two or more times in any one fractional period; again he may not see the patient at all during a fractional period. If the physician considers that he has rendered normal ante-partum care during any trimester or any fractional period of a trimester, his statement will be unquestioned unless gross information to the contrary is brought to the attention of the fiscal agent.

The **week of pregnancy** will be determined by recognized professional methods. Unless a gross error is recognized, the physician's determination of week of pregnancy will not be questioned.

"FULL MATERNITY CARE"

A physician rendering ante-partum care beginning anytime within the first eight weeks of pregnancy and continuing with the patient through delivery and post-partum care, is entitled to full maternity care (Code 4821) if he does not submit his statement until post-partum care is completed. If the physician submits statements for trimester payments, as is his privilege to do so, he must calculate the amounts due in accordance with the scale using recognized professional methods in computing the weeks of pregnancy concerned.

If pregnancy terminates in **abortion or miscarriage**, the physician is entitled to the fee prescribed under Codes 4850, 4851, 4855 or 4860 (all dealing with miscarriage or abortion), whichever is applicable plus fee for whatever ante-partum care he has rendered in accordance with the above scale.

If pregnancy terminates in **premature delivery**, the physician is entitled to full fee (Code 4821) if he has rendered continuous ante-partum care beginning in the first eight weeks of pregnancy and, of course, if he renders care through delivery and the post-partum period provided he has not already submitted statements for trimester ante-partum care.

If physician has not rendered full ante-partum care, the allowance for ante-partum care is calculated as per examples for term delivery. In other words, the nine weeks immediately preceding delivery (even if premature) will be considered as the third trimester for calculation purposes. A premature delivery for purposes of this subparagraph will be that determined by recognized professional methods and will not be confused with abortions or miscarriages which are covered elsewhere.

The physician's diagnosis of premature delivery will not be questioned unless a statement made on his statement of services is obviously grossly in error.

CESAREAN SECTION

If pregnancy terminates in any type of **Cesarean** section and the patient is referred to another physician for this operation, the referring physician is entitled to fee for any ante-partum care he may have rendered and to the fee for post-partum care if he renders this service.

The fees for **Cesarean Sections** are considered to be inclusive of ante and post-partum care. If the physician doing the Cesarean Section has previously received fees for ante-partum care, either from the patient (prior to eligibility under the Program) or the Government, he should deduct the amount received from his statement.

If, however, he has not rendered ante-partum care, he should render his statement to the fiscal agent with a special report justifying the charge he considers reasonable. This report will be submitted to the fiscal agent who in turn will obtain advice of the medical society and forward to the Office for Dependents' Medical Care for adjudication.

If a maternity patient should have to consult a physician in a locality away from that of her attending physician or clinic, the physician consulted is entitled to fee for a **home or office visit** under Code 0010 or 0011, whichever is applicable. (This has reference to his being consulted on a condition connected with the pregnancy and does

not include any condition which is foreign to the pregnancy for which the Government or the patient may be responsible in accordance with the provisions of the Program.)

CHANGE OF PHYSICIAN

If a patient finds it necessary to **change physicians** because of change of station or for other reasons, each physician rendering ante-partum care is entitled to fee in accordance with the above scale for the ante-partum care rendered by him.

Physicians may add to their statements (DA Form 1863) those **drug items** which have been directly or indirectly furnished to the maternity patient. (Direct furnishing of drugs is: supplying drugs by the physician's office to the patient; indirect furnishing is: the physician writes a prescription to the patient but has the pharmacy bill him (the physician) for the drugs dispensed.)

A physician may also add to his statements the cost of **laboratory work** performed for maternity patients in his office or for work performed in a laboratory for which the physician has paid. If the laboratory is operated by a physician, the laboratory physician may submit a statement for service rendered indicating that he has rendered the service at the request of the attending physician.

MULTIPLE BIRTHS

A physician, if he feels that remuneration above that called for in the Schedule is justified by multiple births (twins, triplets) or other complications of pregnancy not specifically covered in the Schedule of Allowances, may submit a **special report** justifying additional charge. This is submitted to the fiscal agent who in turn will obtain advice of the medical society and forward to the Office for Dependents' Medical Care for adjudication.

ACUTE EMOTIONAL DISORDERS

Pertinent excerpts from the special bulletin on emotional disorders are as follows:

Treatment of nervous and mental disorders is not authorized under the provisions of the Dependents' Medical Care Act, Public Law 569, 84th Congress, except in special and unusual cases.

The authority is given the Secretary of Defense to make exceptions for hospitalization of patients for nervous and mental disorders in uniformed services medical facilities. However, beds available for women and children in uniformed services medical facilities for the treatment of nervous and mental disorders are few in number. Therefore, transfer from civilian facilities to uniformed services facilities in the continental United States will rarely be accomplished.

PENDING ARRANGEMENTS

Paragraph 502 g of the Joint Directive recognizes the need for authority to hospitalize in civilian facilities cases of acute emergency, including acute emotional disorders. The mentioned paragraph states that "Hospitalization is authorized at Government expense for such emergencies only pending completion of arrangements for care elsewhere" unless the illness qualifies for hospitalization under another provision of the law, such as pregnancy. This is interpreted to mean that the Government is liable for payment of the hospital and physician's bills only:

a. Until the acute emotional disturbance subsides; or

b. Until the sponsor can arrange for care at other than Government expense, whichever is earlier.

The judgment and integrity of the attending physician must be relied upon to determine when the acute emotional disturbance subsides and his word will be unquestioned, except when there is evidence to the contrary. Likewise, the judgment of the physician must be relied upon to determine the probable duration of hospitalization which will be required for each individual patient.

In order to establish a working arrangement so that Fiscal Administrators will be able to handle many cases without referral to the Office of Dependents' Medical Care, bills may be paid without further reference:

a. If the physician states the condition was one of acute emotional disorder constituting an emergency requiring hospitalization for the life, health or well-being of the patient, regardless of psychiatric diagnosis; and

b. If the duration of hospitalization for the acute emotional disorder did not exceed 21 days.

When the Government's liability terminates not later than 21 days, the DA Form 1863 for the physician and hospital should show the type of disposition which has been made. This will aid contractors in making prompt payments.

Extension of medical care beyond 21 days at Government expense may be granted only by the Contracting Officer, Office for Dependents' Medical Care and the basis for such extension is as follows:

a. Extensions beyond 21 days will be granted for short periods of time for the following reasons:

(1) When there is necessity for more time for the sponsor to assume responsibility. Examples: (a) Sponsor's return from overseas station, sea duty, etc.; (b) Difficulty in obtaining agreement of state or municipal institution to accept patient.

(2) When retention in the hospital for a matter of two or three weeks will result in a cure or remission which will permit patient to return home.

(3) When underlying diagnosis for determination of length of care cannot be made within the 21-day period.

b. A suggested procedure for requesting an

extension of hospitalization beyond 21 days follows:

(1) Upon admission of a patient under the Dependents' Medical Care Program, the hospital administrator should immediately contact the charge physician to ascertain the length of time hospitalization will be required for the acute emergency.

(2) If the attending physician is of the opinion that hospitalization will be required beyond a 21-day period, the hospital administrator should immediately prepare a report containing information specified in subparagraph (3) below and forward to the Contracting Officer, Office for Dependents' Medical Care, through the contractor. Because of the shortness of time, this report should always be submitted by the end of the first seven days of hospitalization and should be forwarded by air mail by all echelons, if more expeditious.

(3) The report will be clinical in nature and will show the name of the dependent, date of admission, diagnosis, prognosis, service member's name, serial number, branch of service, the physician's name, and the length of time for which extension of hospitalization at Government expense is requested with appropriate reasons therefor.

Procrastination and delay on the part of an available sponsor to arrange for care of the patient at other than Government expense will in no case be considered reason for extension of the 21-day period.

Physicians accepting patients with acute emotional disorders under the Dependents' Medical Care Program have the great responsibility of making recommendations which are compatible with the Law governing the Program. They must determine that the acute emotional disorder is one which constitutes an acute emergency and that hospitalization is necessary for the life, health or well-being of the patient. They should institute treatment as indicated and at the same time begin discussions with the sponsor which will lead to the proper treatment and care of the patient at other than Government expense.

Traffic Death Rate Among Males Reaches Peak at Age 21

The motor vehicle accident death rate among males during the years 1953-55 rose sharply from an average of less than 10 per 100,000 at ages 1-14 to a peak of 64.1 per 100,000 at age 21. The rate for females at age 21 was 8.4 per 100,000.

Among females, there was a comparatively gradual rise in the death rate from this cause during the teen ages, with a rate of 13.4 per 100,000 at age 18, but the peak rate, 16.0 per 100,000, occurred at ages 65-74 years.—Metropolitan Life.

American College of Chest Physicians Program Includes Ohioans

Several Ohio physicians are scheduled to participate in the program of the American College of Chest Physicians at the Hotel Commodore in New York City, May 29 - June 2. The meeting precedes that of the American Medical Association which meets also in New York, June 3 - 7.

Details of the program may be obtained by writing the American College of Chest Physicians, 112 East Chestnut St., Chicago 11, Illinois.

Among Ohioans on the program are the following whose subjects are indicated:

Dr. Ray W. Kissane, professor of medicine in cardiology, Ohio State University, Columbus, "Management of the Coronary Patient."

Dr. Claude S. Beck, professor of cardiovascular surgery, Western Reserve University, Cleveland, "Surgery of the Coronary Artery."

Dr. Karl P. Klassen, professor of surgery and chief of the thoracic surgery service, Ohio State University, Columbus, "Surgery of Congenital Heart Disease."

Dr. Joseph F. Tomashefski, chief of research and director of the Cardio-Pulmonary Laboratory, Ohio Tuberculosis Hospital, Columbus, "Compliance and Resistance."

Dr. Frank Princi, associate professor of industrial medicine, University of Cincinnati School of Medicine, participating in roundtable discussion on "Occupational Diseases of the Lungs."

Dr. Maurice Schnitker, director of medicine and chief of medical service at St. Vincent's Hospital, Toledo, participating in roundtable discussion on "Hypertension."

More Than $3-Million From Ford Fund Goes to Western Reserve

The Ford Foundation gift to Western Reserve University School of Medicine amounts to $3,100,000, according to an announcement in the public press late in March. This figure includes $500,000 previously announced.

The grants are to be held as invested endowment for at least 10 years. During this time income from the endowment may be spent only for instructional purposes. After a decade the medical school is free to use the principal sum as well as endowment income.

Dr. Joseph T. Wearn, dean of the Medical School, announced that income from the grant would show up in the budget effective July 1, according to the public press.

The grant is part of the $90-million distributed by the Ford Foundation to privately operated medical schools. Dr. Wearn further stated that, except for the big medical schools, Western Reserve's grant ranked near the top of the list in amounts given.



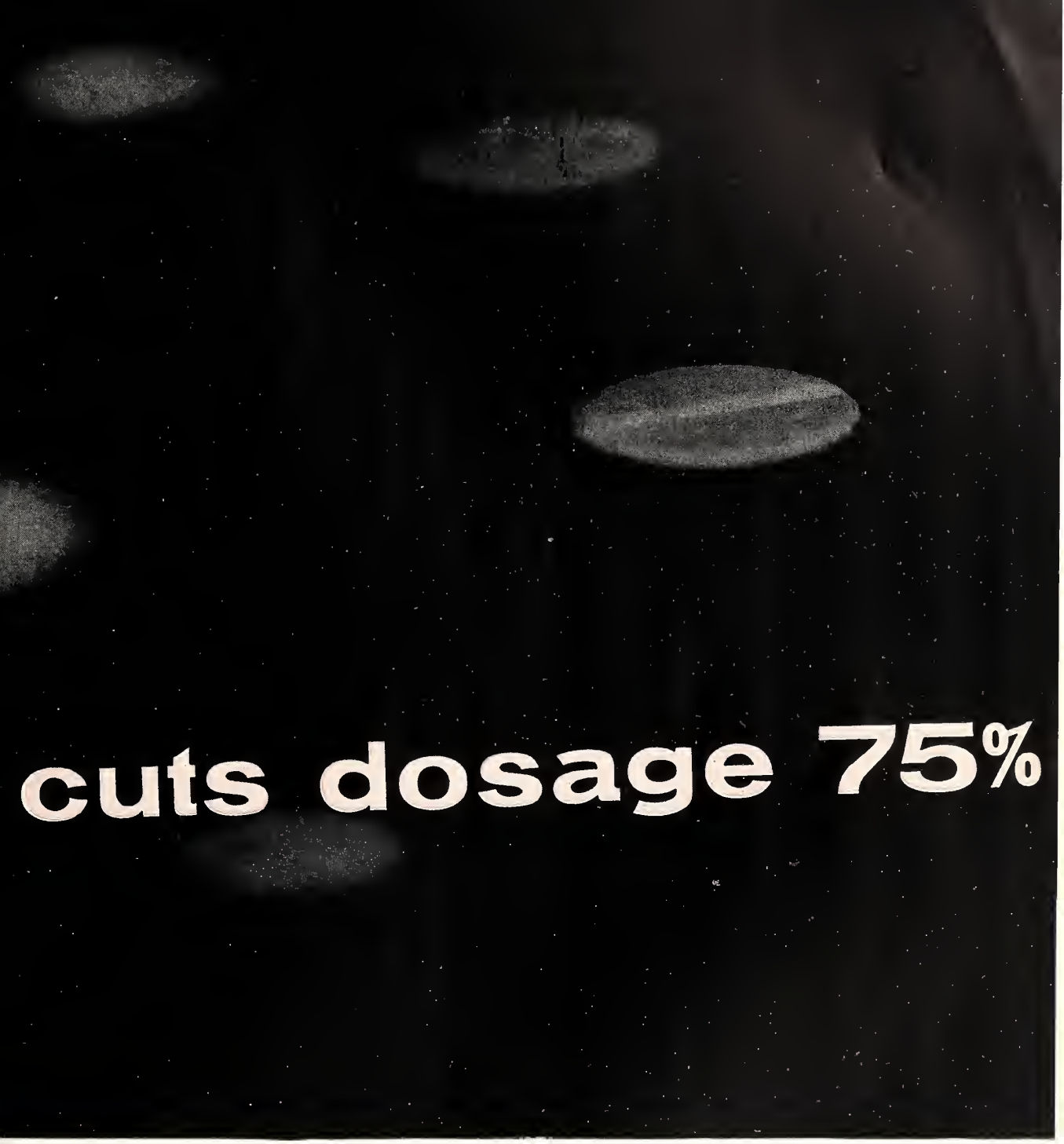
an entirely new, readily soluble,

single sulfonamide exhibiting

excellent antibacterial action

at radically reduced dosage

KYNEX SETS A NEW STANDARD FOR SULFA THERAPY



LOW DOSAGE: a total maintenance dose of only 2 tablets daily.

SOLUBILITY: prompt absorption, ready diffusion into body fluid and tissue.

PROLONGED ACTION: therapeutic blood levels within the hour, blood concentration peaks within 2 hours—5-10 mg. per cent blood levels persist 24 hours after a single oral dose of 1 Gm.

BROAD-RANGE EFFECTIVENESS: KYNEX is particularly efficient in urinary tract infections due to sulfonamide-sensitive organisms, including E. coli, Aerobacter aerogenes, paracolon bacilli, streptococci, staphylococci, Gram-negative rods, diphtheroides and Gram-positive cocci.

SAFETY: KYNEX offers a margin of clinical safety based on low required dosage, solubility, slow excretion rate. Although KYNEX Sulfamethoxypyridazine is a sulfonamide derivative and the usual precautions regarding such drugs should be observed, the low daily dose of 1.0 Gm. is all that is required for therapeutic blood levels. No increase in dosage is recommended.

CONVENIENCE: The low adult dose of 1 Gm. (2 tablets) per day offers optimal convenience and acceptance to patients.

TABLETS: Each contains 0.5 Gm. (7½ grains) sulfamethoxypyridazine. Bottles of 24 and 100.

SYRUP: Each teaspoonful (5 cc.) contains 250 mg. sulfamethoxypyridazine. Bottle of 4 fl. oz.

*REG. U. S. PAT. OFF.

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

Lederle

Will Entertain Members and Guests at the Annual Banquet



This singing group known as "The King's Guard" will present a versatile program for entertainment of members and their ladies. The group's record speaks for itself with recent engagements on the Wayne King Show, at the Sahara Las Vegas, the Palmer House in Chicago and other leading hotels throughout the country.



Harry Jarkey, talented comedian will perform following the Banquet and emcee the show that promises an evening of top entertainment and enjoyment for all present.

The Annual Banquet—a break for a bit of fun in an otherwise compact program—offers members, their ladies and other guests an evening of entertainment and relaxation. The Banquet begins at 7:30 p. m. on Wednesday, May 15.

Official proceedings will be at a minimum—introduction of Officers, Councilors and distinguished guests, and the procedures that complete an official gathering.

The Hon. C. William O'Neill, Governor of Ohio and Mrs. O'Neill will be introduced and the Governor will speak briefly.

The entertainment that follows has been selected especially for the OSMA Banquet and is some of the finest available. The remainder of the evening will be devoted to dancing to the accompaniment of Chuck Selby's Orchestra.

Members are advised to secure tickets at $7.50 per person as soon as possible. Tickets may be ordered by mail from the OSMA Columbus Office up to the time of the meeting. After the meeting has started tickets may be purchased at Registration Headquarters in the Veterans Memorial Building.

Resumé of the 1957 Annual Meeting Program

Ohio State Medical Association, Columbus, May 14-16

Events are in the Veterans Memorial Building unless otherwise indicated.

TUESDAY, MAY 14

Specialty Section Programs (9:30 to 11:00 a. m. and 11:30 to 12:30):

- **Section on Industrial Medicine.**
- **Section on Obstetrics and Gynecology.**
- **Section on Otorhinolaryngology.**
- **Joint Session: Section on Physicial Medicine and Section on Surgery.**
- **Section on Urology.**

General Sessions:

- **"The Doctor and the Law"**—A Panel Discussion; 2:00 to 3:00 p. m.
- **"Management of Automobile Injuries"**—A Symposium; 3:30 to 5:00 p. m.

WEDNESDAY, MAY 15

Specialty Section Programs (9:30 to 11:00 and 11:30 to 12:30)

- **Joint Session: Section on Anesthesiology and Section on Neurological Surgery.**
- **Joint Session: Section on General Practice and Section on Internal Medicine.**
- **Section on Ophthalmology.**
- **Section on Pediatrics.**
- **Section on Radiology.**

Workshop on Medical Writing (10:00 a. m. to noon).

Specialty Society Meeting:

- Ohio Chapter, American College of Chest Physicians; 2:00 p. m.

General Sessions: (2:00 to 3:30 and 4:00 to 5:30 p. m.).

- **"The Surgical Treatment of Parkinson's Disease."**
- **"Mistakes in the Handling of Congestive Heart Failure."**
- **"The Problem of Pain: Diagnosis and Treatment."**
- **"The Medical Witness,"** Motion Picture Presentation and Panel Discussion.

The Annual Banquet: 7:30 p. m. in the Grand Ballroom of the Neil House—dinner, entertainment, dancing and an evening of fun for all.

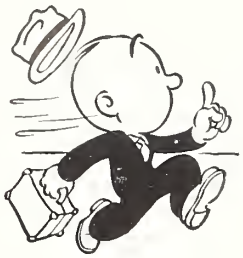
THURSDAY, MAY 16

General Sessions:

- **"Physicians and Their Investments,"** first part of 10:00 to 11:00 a. m. session.
- **"Planning Your Estate,"** second part of 10:00 - 11:00 a. m. session.
- **"Persistent Diarrheas,"** 11:30 a. m. to 12:30 p. m.
- **"The Malpractice Problem and What's Being Done To Cope With It,"** first part of 2:00 to 3:00 p. m. session.
- **"Oral Hypoglycemia Agents,"** second part of 2:00 to 3:00 p. m. session.
- **"Antimicrobial Therapy in Special Fields,"** 3:30 to 4:30 p. m.

House of Delegates: Noon luncheon in the Neil House for members of the House of Delegates will be followed by second and final business session.

Outstanding features of the Annual Meeting are the Scientific and Educational Exhibits and the Technical Exhibit. These displays in the Veterans Memorial Building are worthy of several visits by members, and for that purpose ample recess periods have been provided throughout the program. Study the lists of exhibitors and make notes of those you wish to see, or just brouse through. You'll find many to interest you.



Oops! Hotel Reservation!

For the 1957 Annual Meeting
Ohio State Medical Association
May 14, 15 and 16 — Columbus

It's a bit late, but worth trying if you haven't already made your hotel reservations. Best policy for late reservations is to phone the hotel of your choice.

NAME AND LOCATION	SINGLE	DOUBLE	TWIN
NEIL HOUSE, 41 S. High St.	$ 6.00-11.00	$ 9.00-11.00	$11.00-14.00
DESHLER-HILTON HOTEL, W. Broad & N. High	$ 5.00-13.50	$11.00-18.50	$11.00-18.50
FORT HAYES HOTEL, 31 W. Spring St.		$ 9.00 up	$ 9.00 up
SENECA HOTEL, 361 E. Broad St.	$ 4.00- 7.00	$ 6.00- 9.00	$ 9.00-12.00
HOTEL SOUTHERN, S. High & E. Main Sts.		$ 8.00 up	$ 9.00 up
VIRGINIA HOTEL, Gay & Third Sts.	$ 7.00- 8.00	$10.00-12.00	$11.00-14.00

Persons who desire additional accommodations are advised to specify their needs to the hotel of choice.
(All Rates Subject to Change)

HOTEL RESERVATION BLANK
Mail the coupon to hotel selected

Manager ..... Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 14, 15, 16, 1957, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price .....

☐ Twin Bed Room with Bath ☐ Other

Arriving May ..... at ..... A. M. ..... P. M.

PLEASE VERIFY MY RESERVATION

Name .....

Address .....

.....

Physician-Lawyer Code . . .

Suggested "Model" Statement of Principles Governing Relationship Between Two Groups Sent to Local Medical and Bar Organizations

A MODEL draft of a suggested "Statement of Principles Governing Certain Physician-Lawyer Relationships" is in the hands of all local medical societies and all local bar associations in Ohio for their consideration and action.

The draft was distributed in mid-March by the Ohio State Medical Association and the Ohio State Bar Association which cooperated in formulating it. The hope of both associations is that it will be adopted, in original or modified form, in all counties which do not have a code in effect. In a few counties a code is in effect.

MOVE STARTED IN CINCINNATI

The pioneer move in bringing about an understanding—in writing—between the medical and legal professions of a county was taken by the Cincinnati Academy of Medicine and the Cincinnati Bar Association a little over two years ago. The project was so successful that other county medical societies and local bar associations decided to consider the adoption of such a code.

In order to assist all county medical societies in initiating such a program locally, The Council of the Ohio State Medical Association instructed the Judicial and Professional Relations Committee to draft a suggested "Statement of Principles Governing Certain Physician-Lawyer Relationships" which could be used by the local societies as the basis for discussions with local members of the legal profession.

HAS TWO-FOLD ENDORSEMENT

Aided by Mr. Wayne E. Stichter, legal counsel of the Association, the committee prepared a proposed statement of principles. It was approved by The Council on February 23, 1957. Conferences had been held previously with officials of the Ohio State Bar Association.

On March 5, 1957, the Executive Committee of the state bar association adopted an identical statement of principles. Thus, the statement, which was transmitted to local medical societies and to local bar associations has the official approval of both state organizations.

The statement of principles, which is appended, has no state-wide force. It is intended only as a "model." It may be adopted locally if agreed to by the local medical society and the local bar association. It may be revised to meet local conditions or views.

It is the recommendation of The OSMA Council that a standing committee of each medical society give this project careful study or that a special committee be named for this purpose. It is suggested the idea be discussed with each local bar association if this has not been done already.

ADVANTAGES SUMMARIZED

The Council believes that the adoption of a statement of principles in each county will do much to clarify misunderstandings between doctors and lawyers; bring about closer cooperation between the two professions; and benefit not only physicians and attorneys but likewise those who need from time to time the combined services of physicians and lawyers.

TEXT OF CODE

Following is the text of the "model" suggested code:

TEXT OF PROPOSED STATEMENT OF PRINCIPLES GOVERNING CERTAIN PHYSICIAN-LAWYER RELATIONSHIPS

Whereas, physicians and lawyers are each members of a profession dedicated to the furnishing of professional skill and service to the public; and

Whereas, a substantial part of the practice of medicine, and of the practice of law, is concerned with medico-legal problems connected with, or arising out of, injuries to, or illness or disability of, members of the public; and

Whereas, certain problems frequently arise in each profession in connection with these medico-legal problems affecting the relationship between the physician and the lawyer, the physician and his patient, and the lawyer and his client; and

Whereas, the public interest, the interest of the physicians and their patients, and the interests of the lawyers and their clients, will best be served by an understanding on the part of each profession as to the function, scope, rights, duties, and responsibilities of the other profession in connection with such medico-legal problems, and by the cooperation of the members of both professions in the solution of such problems;

Now, Therefore, the following Statement of Principles is hereby adopted by the _____ Medical Society and the _____ Bar Association:

1. Each profession recognizes that practitioners in the other profession have qualified for their particular license and practice by specialized training, and by demonstration of the necessary character and integrity for the service of members of the public:

2. Each profession recognizes that the training, knowledge, skill, advice, and time of the members of the other profession are the means by which

such members earn their livelihood, and that the most efficient and effective use of such talents in dealing with any problem involved in, or arising out of, the physician-lawyer relationship requires a due regard and proper consideration for the function, scope, rights, duties, and responsibilities of the other profession with respect to such problem.

A. REPORTS TO BE FURNISHED BY THE PHYSICIAN

1. Authorization of Patient Required.

No lawyer should request of a physician, and no physician should furnish to any person, any information concerning the history, physical condition, diagnosis or prognosis of the physician's patient except upon the signed authorization of the patient (or, in the case of a minor, of the minor's parent or guardian); provided, however, that this principle shall not affect the giving of written medical reports by a physician to the Industrial Commission on behalf of patients whose treatment or examination is to be paid for by the Industrial Commission.

2. Reports to Patient or his Attorney.

The patient, or his attorney as his duly authorized agent, shall be entitled, upon written request, to a prompt report from the attending or treating physician concerning the history, findings, treatment rendered, diagnosis and prognosis, and the charge, if any, for such report should be commensurate with the time and effort devoted to its preparation; however, in the absence of unusual circumstances, simple status reports, or simple reports in the nature of a proof of claim or loss, should be furnished without charge.

3. Reports to Others.

Where the physician's report is requested by or on behalf of someone other than the patient or the patient's attorney, the patient's physician should obtain written authorization from his patient before giving the request report or any information relating to his patient; and in such case the physician shall be entitled to charge a reasonable fee for the preparation of such report, the amount of such fee to be agreed upon between the physician and the person requesting the report.

4. Request for Report.

When a medical report is requested of a physician, whether he be an attending physician, consulting physician, or examining physician, the lawyer requesting the report should make clear in his request the specific information desired; should disability evaluation and prognosis be desired, the lawyer should so specify. The physician, upon receipt of such request accompanied by such authorization as may be necessary, should furnish the requested report promptly.

5. Examination of Adverse Party or Employee.

If a medical examination is requested or arranged by a party adverse to the individual to be examined, or by a prospective employer as a pre-employment medical examination, the report of such examination should be made directly to the person arranging for such examination. Unless otherwise authorized or instructed by the person requesting the medical examination, the examining physician should not furnish to the person examined or his attorney, or anyone else, a copy of such report or any information concerning his findings on such examination.

B. PHYSICIANS CALLED AS WITNESSES IN LEGAL PROCEEDINGS: PREPARATION AND ARRANGEMENTS FOR THE GIVING OF TESTIMONY: WITNESS FEES.

1. Conference Before Trial.

It is the duty of each profession to present fairly and adequately the medical questions involved in legal controversies; to that end, the practice of pre-trial discussions, between the physician who is to testify and the lawyer calling such physician as a witness concerning the medical questions involved, is encouraged and recommended. It is recognized that it is always proper, and in most instances quite desirable from the standpoint of the physician and the lawyer, that a conference should be held between the patient's physician and the patient's lawyer at some mutually convenient time before the physician is to testify. Likewise, the physician who has made an examination of a person at the request of a party adverse to the person examined, and the lawyer planning to call such physician as a witness, should hold a conference at some mutually convenient time before such physician is to testify.

2. Subpoena for Physician; Conference; Conference Fee.

No lawyer should cause a subpoena to be issued for any physician who has examined or treated the lawyer's client without prior conference with such physician concerning the matters regarding which he is to be interrogated, unless the physician and the lawyer agree that such conference is unnecessary, or unless the physician refuses to confer. The fee, if any, to be charged by the physician to the patient for such conference should be a matter of agreement between the physician, the lawyer, and the patient.

No lawyer should cause a subpoena to be issued for any physician employed by the lawyer, or the lawyer's client, to make an examination of a person adverse to the lawyer's client without prior conference with such physician concerning the matters regarding which the physician is to be interrogated, unless the physician and the lawyer agree that such conference is unnecessary, or unless the physician refuses to confer. The fee, if any, to be charged to the lawyer's client for such conference should be a matter of agree-

ment between the physician, the lawyer, and his client.

3. Cooperation With Court.

It is recognized that the proper and efficient dispatch of the business of the courts cannot depend upon the convenience of litigants, the lawyers or the witnesses, including physicians who may be called to testify; both the lawyer and the physician should recognize, accept and discharge their obligation to aid and cooperate with the courts in the presentation of medical testimony.

4. Arrangements for Court Appearance.

In arranging for the attendance of a physician at a trial, or other legal proceeding, the lawyer should always have due regard and consideration for the professional demands upon the physician's time, and, accordingly, the lawyer should whenever possible, give the physician reasonable notice in advance of his intention to call the physician as a witness, of his intention to issue a subpoena for the physician's attendance, and of the probable date on which the physician will be expected to testify; and the lawyer should also advise the physician to bring with him to court such records as the lawyer or the physician may need for the proper presentation of the physician's testimony. Furthermore, during the course of the trial the lawyer should endeavor to keep the physician advised from time to time as to the approximate hour when he will be called to the witness stand; and upon the physician's appearance at the hearing at the hour agreed upon the lawyer should endeavor to arrange with the court for the prompt calling of the physician to the witness stand.

5. Fee for Court Appearance.

When a physician is called to testify as a witness for his patient, the charge, if any, should be made to the patient. The amount of such charge should be determined by conference between the physician and his patient, or the patient's attorney, well in advance of the physician's appearance in court.

6. Expert Testimony.

A reasonable expert witness fee is a proper and necessary item of expense in litigation involving medical questions; and when a physician is called to testify as an expert witness he should be paid such expert witness fee as may be agreed upon between the physician and the lawyer calling him; and in every instance in which the lawyer makes arrangements for expert testimony it shall be the duty of the lawyer to see that adequate arrangements for the payment of such expert witness fee have been made.

7. Contingent Fees.

Neither the physician called as a witness nor the lawyer so calling him shall invite or enter into any arrangement whereby the making of a charge for the physician's appearance as a witness or for the giving of testimony, or the amount of any such charge, shall be contingent on the outcome of the litigation or on the amount of damages awarded in the case.

C. SETTLEMENTS

Payment of Physician's Services out of Proceeds of Settlement.

It is recognized that the professional charges of a physician are due when a statement for the physician's services has been rendered to the patient. In any case in which the physician has not been fully paid by his patient, either for his regular professional services or for his time as a witness, or both, and there is no dispute as to the propriety or reasonableness of the physician's charges, the patient's lawyer, upon the receipt of the proceeds of settlement of the claim of the patient for an injury, illness or condition for which the physician has treated the patient, or with respect to which injury, illness or condition the physician has testified on behalf of the patient, should request the permission of the patient to pay the physician direct for the physician's charges out of the proceeds in the hands of the lawyer. The lawyer should not charge a fee to the physician for the collection and payment of the physician's charges out of any such proceeds in the hands of the lawyer.

D. JOINT CONFERENCE COMMITTEE

Appointment and Function of Committee.

For the purpose of promoting and perpetuating harmony, understanding and improved relations between physicians and lawyers, and for the purpose of improving and revising from time to time this Statement of Principles, a Joint Conference Committee, composed of three physicians and three lawyers, shall be appointed annually by the Presidents of the ..... Medical Society and the ..... Bar Association, respectively. The Joint Conference Committee shall select its own Chairman from among the Committee's members; such Chairmanship shall alternate annually between the members of the ..... Medical Society and the members of the ..... Bar Association.

E. GENERAL PROVISIONS

Nothing contained in this Statement of Principles is intended to alter the rules of law with reference to the attendance of witnesses and fees for their attendance, nor the rules of law with reference to privileged communications.

Adopted: February 23, 1957,
by The Council, Ohio State
Medical Association.

Conference of County Society Officers . .

Local Organizations Well Represented in Columbus Meeting; Subjects That Are of Mutual Interest on State and County Levels Are Discussed

OHIO'S County Medical Societies were well represented when key persons in the local organizations met with officers of the Ohio State Medical Association in the Conference of County Medical Society Officers and Committeemen in Columbus February 24.

Guest speakers for the occasion were Dr. Thomas H. Alphin, director of the Washington Office of the American Medical Association, and Loren Schultz, city editor of the *Springfield Daily News*.

Dr. Alphin's talk entitled "The Doctors' Stake in Legislation," stressed the growing importance of medical and health matters being introduced into Federal law. During the 1955-1956 sessions of Congress some 571 bills with medical and health implications were introduced. Yet more than this number had already been introduced during the early weeks of the 1957 session, Dr. Alphin pointed out.

Dr. Alphin concluded his talk by reminding his audience that the only effective way to influence legislators is to contact them from their home state or home county. One of the services of the Washington Office of the AMA is issuance of a regular informational bulletin which goes to legislative committeemen and other key persons in each County Medical Society.

TEAMWORK AND THE PRESS

Mr. Schultz spoke to the conference on the subject, "Teamwork Between the County Medical Society and the Press." There are more newspapers sold in the United States every day than loaves of bread or bottles of milk, Mr. Schultz stressed, reminding physicians that the newspaper is the main medium of authentic communication in the community. He cautioned his hearers about the reluctance of some physicians to give newspapers authentic information because they "don't want to cause an alarm," while much less informed persons are spreading the alarm about town. Springfield is only one of many communities in Ohio where the County Medical Society has a working agreement with the local newspaper. In many communities key physicians have been designated who may be called by the newspaper when authentic information on medical and health matters is needed.

Following Dr. Alphin's talk on Federal legislation, George H. Saville, director of public relations for the OSMA, took up the theme, "The Doctors' Stake in Legislation," and discussed it from the standpoint of the Ohio General Assembly. Mr. Saville reviewed some of the many resolutions pertaining to medical and health matters introduced in the Ohio Legislature and again stressed the importance of doctors contacting their representatives from the local level.

Hart F. Page, assistant public relations director, gave a series of "Hints and Hunches for County Society Presidents and Secretaries." He suggested many services of the OSMA Columbus Office available to County Society officers, and discussed means of improving contacts between local Societies and the State Office.

"MEDICARE"

Dr. Charles L. Hudson, Cleveland, Immediate Past-President of the OSMA, reviewed "The Medicare Program," the new Federal Medical Care Program for Military Dependents.

Screened during the program was the AMA-sponsored film "Case of the Doubting Doctor." This film, which stressed in dramatic sequence, the values of Medical Societies, is available for local showing.

Dr. Richard L. Meiling, Columbus, President of the OSMA, opened the program with a brief talk and presided during the morning session. Dr. Robert S. Martin, Zanesville, President-Elect of the State Association, presided at the afternoon session.

An important part of the program was the period given to conferences of the 11 Councilor Districts. This period gave each Councilor an opportunity to meet and discuss informally matters of particular interest in the districts.

Following these informal discussion periods, luncheon was served in the Main Ballroom of the Deshler-Hilton Hotel.

THOSE PRESENT

Those registered at the conference included the following:

OFFICERS AND COUNCILORS: R. L. Meiling, Columbus, President; Robert S. Martin, Zanesville, President-Elect; Charles L. Hudson, Cleveland, Past-President; Geo. J. Hamwi, Columbus, Treasurer; First District Councilor, Frank H. Mayfield, Cincinnati; Second District, G. A. Woodhouse, Pleasant Hill; Third District, James R. Jarvis, Van Wert; Fourth District, Paul F. Orr, Perrysburg; Fifth District, George W. Petznick, Shaker Heights; Sixth District, C. A. Gustafson, Youngstown; Seventh District, R. E. Hopkins, Coshocton; Eighth District, William D. Monger, Lancaster; Ninth District, C. L. Pitcher,

(Continued on Page 576)

Councilors Get Together with Respective District Groups



First District—Presiding is Dr. Mayfield (center).



Second District—Dr. Woodhouse (back to window) presiding.



Third and Fourth Districts Combined—Dr. Jarvis, standing; Dr. Orr, seated at head of table.



Fifth District—Dr. Petznick is seated in center partly behind district sign.



Sixth District—Dr. Gustafson (center) presiding.



Seventh District—Dr. Hopkins (not shown in picture) presiding.



Eighth District—Dr. Monger (to right facing camera) presiding.



Ninth District—Short in numbers but represented. Dr. Pitcher at right.



Tenth District—Presiding was Dr. Artman (hidden from sight).



Eleventh District—Dr. Pease (center) presiding.

Portsmouth; Tenth District, Edwin H. Artman, Chillicothe; Eleventh District, H. T. Pease, Wadsworth.

FIRST DISTRICT: **Butler County**—Ralph H. Leyrer, Hamilton; John Perkins and W. A. Reese, Middletown; **Warren County**—Thomas E. Fox, Mason; Howard G. Berninger, Lebanon.

SECOND DISTRICT: **Clark County**—J. D. LeFevre, and Ray M. Turner, Springfield; **Darke County**—V. Ray Boli, Westbrook Browne, and Maurice Kane, all of Greenville; **Greene County**—P. D. Espey and Benjamin F. Lee, Xenia; J. R. Schauer, Fairborn; **Miami County**—Dale A. Hudson, Piqua; **Montgomery County**—A. V. Black, Centerville; R. Dean Dooley, Mr. Robert F. Freeman, A. Ward McCally, and Merrill D. Prugh, all of Dayton; **Shelby County**—George J. Schroer, Sidney; J. W. Tirey, Anna.

THIRD DISTRICT: **Allen County**—David L. Steiner, and Walter E. Yingling, Lima; **Auglaize County**—W. V. Barton, St. Marys; **Hancock County**—R. Grant Janes, Findlay; **Logan County**—Charles H. Thompson, West Mansfield; **Marion County**—John T. Boxwell, Marion; **Wyandot County**—R. L. Garster, Allen F. Murphy, Upper Sandusky.

FOURTH DISTRICT: **Defiance County**—J. F. Holtzmuller, Defiance; **Henry County**—Thomas F. Tabler, Holgate; **Lucas County**—A. A. Brindley and Mr. R. W. Elwell, Toledo; **Ottawa County**—George A. Boon, Oak Harbor; C. R. Wood, Port Clinton; **Putnam County**—James B. Overmier, Leipsic; **Williams County**—Robert A. Gilreath, Bryan; **Wood County**—J. Victor Pilliod, Grand Rapids.

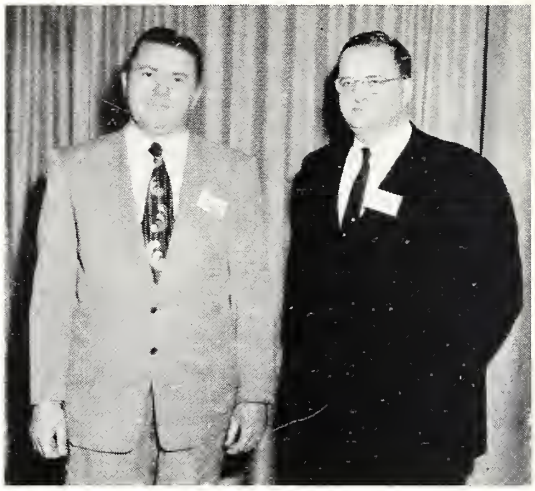
FIFTH DISTRICT: **Ashtabula County**—H. C. Franley, Jefferson; **Cuyahoga County**—E. A. Ferreri, Shaker Heights; Mr. M. John Hanni, C. R. Jablonoski, Thomas D. Kinney and Harry V. Paryzek, all of Cleveland.

SIXTH DISTRICT: **Mahoning County**—Stephen W. Ondash, Youngstown; **Portage County**—Arthur Knight, Apco; R. P. McCormick, R. E. Roy, Ravenna; **Summit County**—Paul A. Davis and Carl C. Nohe, Akron;

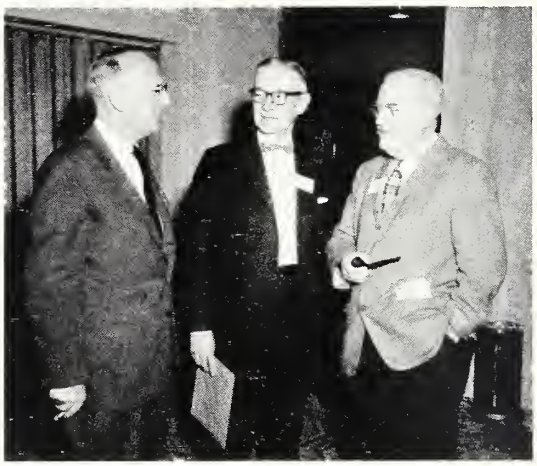
SEVENTH DISTRICT: **Belmont County**—A. J. Antalis, Powhatan Point; David Danenberg, Bridgeport; B. C. Diefenbach and Bertha M. Joseph, Martins Ferry; **Carroll County**—Carl A. Lincke, Carrollton; **Harrison County**—G. E. Henderson, New Athens; **Jefferson County**—W. G. Snyder, Wintersville; **Tuscarawas County**—Jay W. Calhoon, Uhrichsville, William C. Roche, Gnadenhutten; Paul D. Hahn and Arthur J. Stevenson, New Philadelphia;

EIGHTH DISTRICT: **Athens County**—E. L. Schmidt, Athens; **Fairfield County**—H. M. Amstutz, George F. Jones and A. B. VanGundy, all of Lancaster; **Licking County**—R. G. Plummer, Newark; **Muskingum County**—L. P. Cassady,

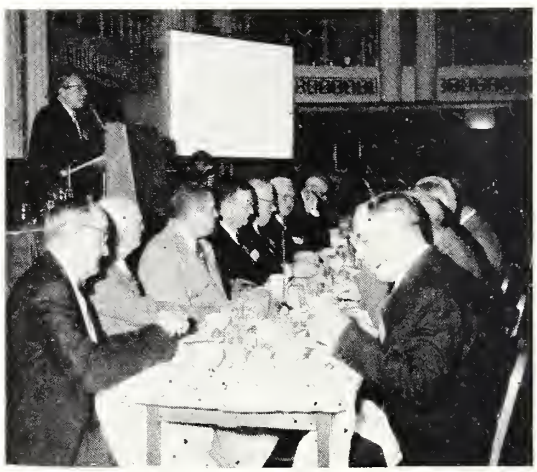
Conference Participants



Guest Speakers—Mr. Schultz of the Springfield News (left), and Dr. Alphin of the Washington Office.



Conferring here are Mr. Wayne Stichter, OSMA legal counsel (left); Dr. Martin, President-Elect (center); and Mr. Saville, PR director.



Shown here during the luncheon period are guest speakers with several Past-Presidents.



Dr. Meiling, OSMA President is seated (left), Dr. Hudson is at rostrum, and Mr. Page, seated right.



Two Past-Presidents of the State Association—Dr. Harry Paryzek (left) and Dr. Platter.

East Fultonham; W. B. Faircloth, Zanesville; **Perry County**—O. D. Ball, New Lexington.

NINTH DISTRICT: **Jackson County**—John M. Cook, Oak Hill;

TENTH DISTRICT: **Delaware County**—F. M. Stratton, Delaware; **Franklin County**—Jonathan Forman, Robert M. Inglis, Mr. Stanley R. Mauck, Charles W. Pavey, H. M. Platter, Norman Rothermich, C. C. Sherburne and Mr. William Webb, all of Columbus; J. L. Henry, Grove City; **Knox County**—James C. McLarnan and Clinton W. Trott, Mt. Vernon; **Ross County**—Lewis W. Coppel, C. N. Hoyt, and Robert E. Quinn, all of Chillicothe; **Union County**—E. J. Marsh, Broadway; May B. Zaugg, and Paul R. Zaugg, both of Marysville.

ELEVENTH DISTRICT: **Erie County**—S. R. Hoover, H. F. Kesinger, Emil J. Meckstroth, all of Sandusky; **Holmes County**—Owen F. Patterson, Millersburg; **Huron County**—N. M. Camardese and O. J. Nicholson, both of Norwalk; **Lorain County**—Wm. E. Kishman and Paul J. Kopsch, Lorain; James T. Stephens, Oberlin; G. R. Wiseman, Amherst; **Medina County**—N. J. M. Klotz, Wadsworth; C. F. Schrier, Litchfield; **Richland County**—C. F. Curtiss, Bellville; Charles R. Keller, H. C. Knierim and Harry Wain, all of Mansfield.

OTHERS: T. H. Alphin, Washington, D. C.; Mr. Loren G. Schultz, Springfield; Mr. Wayne E. Stichter, Toledo, Legal Counsel for OSMA; Mr. Albert C. Joseph, Attorney, Martins Ferry; and Messrs. Nelson, Saville, Page, Moore, and Edgar of the OSMA executive staff.

American Board of Obstetrics

Applications for certification (American Board of Obstetrics and Gynecology), new and reopened, for the 1958 Part I Examinations are now being accepted. Current Bulletins outlining present requirements may be obtained by writing to the Secretary's office: Robert L. Faulkner, M. D., American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

Deadline Set on Health Care Claims Under Aid for the Aged

A communication from the Division of Aid for the Aged places a time limit beyond which it will not honor Health Care Claims for services rendered prior to July 1, 1956.

This policy is necessary, the communication states, in order that all outstanding Health Care Claims for services prior to July 1, 1956, may be certified from appropriations available in the 1956-1957 fiscal year, (that is the fiscal year beginning July 1, 1956 and ending June 30, 1957).

This situation has arisen in a number of cases in which continued medical care by physicians has extended over a long period of time. The communication requests that all claims for services prior to July 1, 1956, be filed by May 1. Since that date will be past by the time this article is read, physicians who have such claims are advised to file them immediately.

The communication concludes: "Any vender who is aggrieved because of rejection of a claim for Health Care services rendered prior to July 1, 1956, made because of the policy established by this letter will be notified of his right to appeal by the Subdivision Office in which his claim was filed."

Largest Gift to Univ. of Cincinnati Is from AMEF Fund

More than $120,000 in gifts and grants and 40 shares of stock were reported by Dr. Walter C. Langsam, University of Cincinnati, president.

Largest was $49,213.78 from the American Medical Education Foundation and National Fund for Medical Education to the National Medical Education Fund.

The UC board accepted a bequest from the late Dr. Joseph E. Ursich establishing, upon the death of his mother and wife, an annual memorial fellowship in his son's name in the College of Medicine for a resident physician or person of higher rank in any clinical branch of medicine. The Ursich bequest is expected to amount to approximately $600 annually.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

LAW ENFORCEMENT A LOCAL RESPONSIBILITY

"O'Neill Sees Vacuum in Law Enforcement" was the headline carried in an article published recently in the *Cleveland Plain Dealer*. It quoted from Governor C. William O'Neill's address to the Cleveland Bar Association. One statement by the Governor was:

"Law enforcement is the responsibility of local government and local officials. But it must be backed up by the close interest of citizens."

That's exactly what we've been telling the State Legislature in arguments against legislation proposed by the chiropractors who have cried: "Give us our own board and we'll clean up the situation." Obviously, that's so much bunk, for as O'Neill has said, law enforcement must take place locally.

That's what we have been telling physicians who complain about unlicensed practitioners in their area or practitioners who exceed their legal rights. Local prosecuting authorities and local courts must handle such cases. Obviously, citizens must actually show their interest in law enforcement and, whenever necessary, bring pressure to bear on enforcement officers and the courts.

Those who look to, and expect, the state to do a job which can only be done locally are just kidding themselves.

SEND YOUR IDEAS ON EXPENSE CUTS TO BRICKER, LAUSCHE

Senator John W. Bricker has had a letter published in the daily newspapers of Ohio asking citizens who want him to vote for a reduction in taxes and in Federal expenditures to be specific. He would like to have examples of where they believe reductions in government costs can be made.

Those who can cite specific examples should write to Senator Bricker. In fact, they should write to him and to Senator Frank Lausche, anyway, suggesting that they use their own judgment and discretion on the matter of cutting down on government costs. They are in a position to know where cuts can be made as they are close to the situation. All they need is backing by their constituents.

The irony of the present drive to get Congress to cut expenditures is that Congress over the years got itself and the nation into the mess by enacting all kinds of questionable and costly give-away programs, subsidies and grants-in-aid projects without thinking about the future financial impact. Now, the job has to be done the hard way—but it should be done.

Perhaps most Congressmen have learned their lesson—the hard way, also. Here's hoping from now on there will be no more following of the slogan which one of the elder statesmen of the past is said to have used as a guide, namely: "The way to stay popular with your constituents and stay in office is to vote for every increase in services and appropriations and vote for every bill to cut taxes." Let's hope also that constituents will let their Congressmen know they think that kind of attitude is not only foolish, but dangerous.

P. S. Do you know that in 1933 there was a single Federal grants-in-aid program—for highways—and that now there are 67 such programs with a total outlay of $5-billion?

USE OF DOUBLE STANDARD OF FEES CAN BE DANGEROUS

Commenting on health insurance coverage, especially with respect nuisance claims, abuses, excessive charges by those providing services, etc., the Medical Services Commission of the California Medical Association makes this pertinent statement:

"It is in our own interest that we learn that charges to patients protected by health insurance should be on the same basis as if they did not have health insurance. Only by such self-discipline can we encourage the development and the success of a sound health insurance industry."

In other words, use of a double standard of fees—if it's an insurance case one fee; if it's not an insurance case, another fee—can be a threat to sound underwriting and insurance financing. Also, such practice might well adversely affect patient-physician relations and public relations of the medical profession as a whole.

LET'S CORRECT OHIO'S POOR ELECTION DAY SHOWING

According to editorial comment in the *Cleveland Plain Dealer*, Ohioans do not have a voting record worth boasting about. Although we don't have the figures, we fear that some physicians are among the guilty folks who fail to show up at the polls on election days.

Here's what the P. D. had to say under the heading, "A Poor Showing"—and let it be a good lesson to those who haven't been voting and an added incentive to those who are in a position to urge their neighbors, friends and colleagues to vote, vote, vote:

"If you're a good citizen you vote—and if

you vote you should be interested in knowing which states got the highest percentage of voting population to the polls in the 1956 presidential election.

"Idaho won first place with 77.3 per cent according to the American Heritage Foundation. Connecticut was second with 76.6. Utah was third with 76.1.

"And where was Ohio?—in 30th place, with only 64.9 per cent!

"A number of nearby states whipped us. Illinois finished eighth with 72.5 per cent; Indiana, ninth, with 72.4 per cent; West Virginia 10th, with almost the same percentage; Michigan 23rd, with 67.1 per cent; New York 27th, with 65.5 per cent; Pennsylvania 28th, with 65 per cent.

"The lesson would appear to be fairly obvious."

INSURANCE GROUP STRESSES SOME PERTINENT FACTS

Physicians in Ohio will find noteworthy some pertinent points emphasized at a recent meeting of the National Health Insurance Council attended by representatives of state medical societies in the eastern United States.

The Health Insurance Council represents eight insurance trade associations whose companies insure more than half of the 110 million Americans having some type of health insurance.

Points of particular interest stressed by speakers at the session were:

1. The value of the independent relationship maintained between the physician, the patient and the insurance company.

2. Standardized and abbreviated claim forms to alleviate excessive paperwork for the physician.

3. The doctor sees in health insurance an opportunity to give greater service to patients.

4. The success of the voluntary health insurance method lies in development of mutual understanding between the insurers and the providers of medical care, and in a mutual desire to "make it work."

That voluntary health insurance does work, is evidenced by the fact that nearly 70 per cent of the population is covered by voluntary plans.

NO MORE HOSPITALS NEEDED FOR SERVICE-CONNECTED CASES

Testifying before a Congressional committee, Veterans Administrator Harvey Higley made this pertinent statement:

"The issue now is narrowing down to this point —does Congress want to build more VA hospitals knowing full well that they will be used for the care of nonservice-connected cases? The hospital plants we now have will care for all our service-connected cases well into the foreseeable future."

When writing your Congressman, you might call his attention to Higley's statement and suggest an indefinite moratorium on VA hospital building.

AGREE U. S. SHOULD EXIT FROM POLIO VACCINE PICTURE

A federally operated allocation system for poliomyelitis vaccine is not necessary to achieve an equitable distribution. This was the opinion expressed by the American Medical Association, the National Foundation for Infantile Paralysis, and the Association of State and Territorial Health Officers to Dr. Leroy Burney, surgeon general of the U. S. Public Health Service, at a meeting recently in Washington.

This is in accord with the standing policy of the Ohio State Medical Association that the Federal Government should let the states and local communities handle the polio immunization programs in a way similar to other immunization programs.

Dr. Burney called the meeting to discuss the supply situation and other aspects of the polio vaccination program. It was also decided that as the vaccine becomes available it should be distributed equitably on a voluntary basis between commercial outlets and public agencies.

The manufacturers' estimate of prospective production was reported to be between 35 and 40 million cc. by July 1. Current production, added to the amount already made available since January 1, will total 75-80 million cc. by July 1. This is equivalent to the total used during 1956.

Areas of general agreement at the meeting were:

- The groups represented should undertake a year-round campaign to promote all-out use of the vaccine.
- The goal of vaccinations for all persons up to the age of at least 40 should be maintained.
- Where there are limited supplies on hand, local preference should be given to the group under 20 and to pregnant women.
- Local communities should be urged to continue their planning so that they can make prompt use of the vaccine as it becomes available.
- Special attention should be given in educational and promotional campaigns to encourage vaccinations of the group under five years of age. This group has by far the highest incidence rate for paralytic polio.
- Every state should have a polio advisory committee to the state department of health.

SUPPORTS OHIO STAND AGAINST NATUROPATHY

Governor LeRoy Collins of Florida has released a report, based on a long investigation, recommending that the Florida law licensing naturopaths be repealed and that naturopathy be outlawed in that state.

All of which attests to the wisdom of the Ohio State Medical Board in refusing to recognize naturopathy and the good sense of the Ohio General Assembly over the years in refusing to enact a law to license naturopaths.

TB Hospital Is Dedicated . . .

New Facility at Nelsonville Serves 14 Counties in Southeastern Area Of State: 77 Beds Are Added to Accommodations for Ohio Program

GOVERNOR C. WILLIAM O'NEILL on March 29 dedicated the state's new 77-bed Southeastern Ohio Tuberculosis Hospital at Nelsonville as "more than just a tuberculosis hospital—it is a focal point for public health services and many other activities for residents of the entire 14-county area to be served by it."

Dr. Harold H. Cashman, director of the hospital, described the institution as "The last word in TB hospital design."

State Senator C. Stanley Mechem, Nelsonville, served as master of ceremonies at the dedication. Remarks were made by Dr. Ralph E. Dwork, director of the Ohio Department of Health; Nelsonville Mayor Earl T. Hilleary and Dr. Cashman.

Dr. Cashman said the functionally modern structure is so constructed as to be converted into a general hospital if that situation should ever develop.

Interior design is aimed at admission of maximum daylight, augmented by the pastel colors used in decoration. Facilities for meal preparation and catering are the latest available, and ample provision is made for occupational therapy, patient recreation, entertainment and morale, he said.

The hospital also has an attractively designed auditorium that can be used not only for hospital gatherings but for community and area meetings as well, particularly medical and health organizations.

Part of the dedication ceremony included the official presentation of the keys to Robert W. Stuart, hospital administrator. The keys were passed from Dan A. Carmichael, architect who designed the hospital, to Zoyd M. Flaler, state director of public works. Mr. Flaler, following appropriate remarks, then presented, in turn, the keys to Mr. Stuart.

The dedication ceremonies were conducted in the auditorium, with some 150 officials of nearby communities, state officials, members of the Legislature, special guests and guests in attendance.

Following the ceremonies, members of the nursing staff conducted guests on tours throughout the new facility.

The hospital is to serve the following counties:

Fairfield, Perry, Muskingum, Guernsey, Morgan, Noble, Monroe, Washington, Hocking, Athens, Vinton, Meigs, Gallia, and Lawrence.

The medical director took his pre-medical and some medical work at West Virginia University, and received his medical degree from Temple University. He served his residency at the Hopemont, W. Va., Sanitarium, returned there several years later as staff physician, and from late 1950 until his current appointment was medical superintendent of the Belmont Sanitarium at St. Clairsville.



Shown at dedication ceremonies opening the state's new Southeast Ohio Tuberculosis Hospital built to serve 14 counties, are (front row, left to right) Nelsonville's Mayor Earl T. Hilleary; Dr. Harold H. Cashman, director of the new institution; Dr. Ralph E. Dwork, director, Ohio Department of Health; Governor C. William O'Neill; State Senator C. Stanley Mechem, of Nelsonville, where the hospital is located, and Zoyd M. Flaler, state director of public works, on extreme right.



This is a general view of the new $1,500,000 Southeast Ohio Tuberculosis Hospital at Nelsonville, dedicated in ceremonies March 29. The hospital, located in Wayne National Forest, overlooking Nelsonville and the Hocking Valley, has a 77-bed capacity.

Pamphlets Give Aids for Patients On Low Sodium Diets

A pamphlet "Planning Low Sodium Meals," and sample meal plans Nos. 1 through 9, are available without charge from city or county health commissioners in Ohio, according to an announcement from Dr. Ralph E. Dwork, director of the Ohio Department of Health. These sample meal plans are for different levels of sodium and calorie restriction, i. e.

200 mg. Sodium, 1200 to 2000 calories;
400 mg. Sodium, 1200 to 2000 calories;
800 mg. Sodium, 1200 to 2000 calories.

A related leaflet, "Facts and Figures for Physicians," is available, also. These materials are supplied to city and county health departments by the Ohio Department of Health.

Regional Conference on Hypertension Scheduled at Ann Arbor

The University of Michigan Regional Conference on Hypertension will take place in Ann Arbor, Mich., June 7-8, in recognition of the 25th anniversary of the first production of experimental renal hypertension by Dr. Harry Goldblatt, of Cleveland. Reports will be presented on the basic mechanisms of renal hypertension, including adrenal, neurogenic and renoprival aspects.

Dr. Goldblatt and other physicians of the regional area will participate. Those desiring to attend are invited to write in advance for information and reservations to Dr. John Sheldon, director, Department of Postgraduate Medicine, University of Michigan Medical School, University Hospital, Ann Arbor, Mich.

State and National Tournaments Hold Promise for Ohio Golfers

Two outstanding golf tournaments are of interest to hundreds of physician golfers in Ohio. The first is the annual tournament of the American Medical Golfing Association scheduled out of New York City, June 3, the week of the AMA Annual Session. The second is the annual tournament of the Ohio State Medical Golfers' Association, scheduled in Columbus, June 21.

The June 3 event is the 41st tournament of the American Medical Golfing Association and will be held at the well known Westchester Country Club, Rye, New York. This resort provides two 18-hole courses and a beach club on Long Island Sound. It is 30 miles from Grand Central Station in New York City and is easily reached by train or bus. All male members of the AMA are eligible to participate.

The annual meeting and tournament of the Ohio State Medical Golfers' Association will be held at the Scioto Country Club, Columbus, on Friday, June 21. This is an all-day outing with tee off time from 9 a. m. to 2 p. m., and the banquet at 7 p. m.

Chairman of the local arrangements committee is Dr. William F. Lovebury, Columbus. Physicians who are not members of the organization and are interested in receiving future notices about activities are invited to write to the secretary, Mr. Robert W. Elwell, executive secretary, Academy of Medicine of Toledo and Lucas County, 3101 Collingwood Blvd., Toledo 10, Ohio.

Further details and registration card for the AMA tournament also may be obtained from Mr. Elwell.

THESE RESOLUTIONS WILL BE PRESENTED TO HOUSE OF DELEGATES FOR ACTION AT 1957 ANNUAL MEETING MAY 14 - 16

UP TO PRESS TIME, the following additional resolutions had been presented to the Columbus Office for publication in *The Journal*, indicating that they will be presented to the House of Delegates for action at the 1957 Annual Meeting, May 14, 15 and 16, Columbus, Ohio. Undoubtedly, additional resolutions will be presented. Delegates should study the following prior to the meeting.

Among resolutions which will be presented are the following which have been approved by the Council of the Cincinnati Academy of Medicine and authorized presented by delegates from that county:

CORPORATE PRACTICE OF MEDICINE

WHEREAS, there have been controversies in the United States and the State of Ohio on the corporate practice of medicine and,

WHEREAS, the definition of the corporate practice of medicine has not been defined by the Ohio State Medical Association,

BE IT RESOLVED, That the Ohio State Medical Association adopt a definition of the corporate practice of medicine for uniform application throughout the State of Ohio.

MALPRACTICE INSURANCE RATES

WHEREAS, There have been continued increases in professional liability or malpractice insurance without accurate statistics being presented for loss ratio experience in the State of Ohio;

BE IT RESOLVED, That the Ohio State Medical Association file a protest under RC 3937.04 if and when the National Bureau of Casualty Underwriters file petitions for further increases of professional liability or malpractice insurance rates.

ACCREDITATION OF HOSPITALS

WHEREAS, The Academy of Medicine of Cincinnati has taken action on the policies of the Joint Commission on Accreditation of Hospitals similar to that of the Stover Committee, whose recommendations were adopted by the House of Delegates of the American Medical Association and subsequently presented by the American Medical Association representatives to the Joint Commission for approval and adoption;

BE IT RESOLVED, That the Council of the Ohio State Medical Association obtain current information on what measures are being taken to correct certain unnecessary requirements that are enforced within the Commission's framework;

BE IT FURTHER RESOLVED, That such information be published in the Ohio State Medical Journal for the general information of the membership with emphasis on those recommendations made by the Stover Committee which were not adopted.

HOUSE OF DELEGATES PROCEDURE

WHEREAS, it is often difficult for delegates to fully understand the intent and meaning of resolutions because of the time element that is always present at Ohio State Medical Association annual conventions,

BE IT RESOLVED, that a committee be appointed by appropriate authorities to study the presentation, referral, discussion and consideration of resolutions in order to make recommendations for better and more effective procedure.

* * *

A resolution to be presented to the House of Delegates of the Ohio State Medical Association by the Stark County Medical Society on Monday, May 13, 1957.

POLICY ON IMMUNIZATIONS

WHEREAS, The Ohio State Medical Association has authorized each county society to administer the Salk and other immunization procedures as the component society so decided; and

WHEREAS, This procedure resulted in many types of divergent plans in the state, resulting in much confusion and unfavorable publicity for some of the county societies; and

WHEREAS, Certain national organizations are entering more and more into the fields of medicine and offering free medicines, vaccines, and attempting to set up nationally, immunization programs other than suitable for local county medical societies;

THEREFORE BE IT RESOLVED, That the Stark County Medical Society recommend to the Ohio State Medical Association and to the American Medical Association that these Associations carefully review their position in approving administration by Boards of Health, medical departments of School Boards, Hospitals, manufacturing companies, labor organizations, etc., of mass inoculation procedures except in epidemics or for indigent programs and approve of these procedures in the private doctor's office or facilities directly under his control and oppose any attempt at regimentation of immunization procedures at the local level which interferes with free enterprise.

* * *

A resolution to be presented to the House of Delegates of the Ohio State Medical Association

by the Stark County Medical Society on Monday, May 13, 1957.

MEDICAL RESEARCH FUND

WHEREAS, In recent years there has been a tremendous increase in organizations to raise funds for medical research and care of patients with specific diseases.

WHEREAS, Much of the money so raised of necessity is used for administration and fund raising purposes

WHEREAS, There is a rapidly increasing infringement by these organizations on the private practice of medicine

WHEREAS, Many important diseases are being relegated to a secondary role because of a lack of research funds

WHEREAS, There is a constantly increasing demand for federal funds for medical research and hence inevitable federal control of medical research

WHEREAS, Each community should be responsible for the care of all indigents regardless of the disease from which they may be suffering

THEREFORE BE IT RESOLVED:

1. All indigent patients regardless of their disease be cared for only by local government funds and funds provided by local private sources such as Community Funds, United Funds, and like charitable organizations.

2. That the Ohio State Medical Association approve:

   a. The establishment of a single national medical research fund to finance medical research into all diseases.

   b. Such national medical research fund to be controlled by physicians.

   c. Such national research fund to be raised by contributions partially from physicians, but chiefly from United Funds or similar charitable organizations throughout the entire United States.

3. That the Ohio State Medical Association instruct its representatives in the House of Delegates of the American Medical Association to expend every effort to assure the passage of the same resolution by the House of Delegates of the American Medical Association.

4. That the AMA upon passage of this resolution take immediate steps in the establishment of this national medical research fund.

Fort Steuben Academy

Dr. Alton Ochsner, professor of surgery at Tulane University School of Medicine, New Orleans, was guest on the April 9 program of the Fort Steuben Academy of Medicine. Local speaker on the program was Dr. Howard Brettell, of the surgical staff of Ohio Valley Hospital. The subject was "Venous Thrombosis." The dinner meeting was held in the Fort Steuben Hotel, Steubenville.

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ANNUAL AUDIT OF BOOKS OF THE OHIO STATE MEDICAL ASSOCIATION AND THE OHIO STATE MEDICAL JOURNAL FOR YEAR ENDING DECEMBER 31, 1956, BY KELLER, KIRSCHNER, MARTIN & CLINGER, CERTIFIED PUBLIC ACCOUNTANTS, COLUMBUS, OHIO

OHIO STATE MEDICAL ASSOCIATION

Cash and Bonds on Hand, January 1, 1956:

Cash in Huntington National Bank	$ 28,686.34
Cash in Ohio National Bank (1957 dues)	39,840.00
U. S. Treasury and Savings Bonds	90,000.00
Total Cash and Bonds	$158,526.34

RECEIPTS

Interest on U. S. Treasury and Savings Bonds	$ 2,327.00	
1956 Membership dues collected in 1956	129,372.50	
1957 Membership dues collected in 1956	36,300.00	
1956 Exhibit space collected in 1956	12,730.00	
1957 Exhibit space collected in 1956	6,403.50	
Banquet tickets sold	2,985.00	
Payment for collection of American Medical Association dues	1,860.38	
1954 AMA dues refund cancelled	25.00	
Total Receipts		$192,003.38
Total To Be Accounted For (Includes 1957 Dues and Exhibit Payments Collected in Advance)		**$350,529.72**

DISBURSEMENTS

The Ohio State Medical Journal	$ 35,000.00	
Executive Secretary, salary	16,500.00	
Executive Secretary, expense	1,923.79	
Stenographic and clerical salaries	31,090.50	
President, expense	992.98	
President-Elect, expense	481.64	
Council, expense	3,929.90	
American Medical Association Delegates	4,722.02	
Dept. of Public Relations:		
Director, salary	$ 14,000.00	
Director, expense	1,434.88	
Asst. Director, salary	9,000.00	
Asst. Director, expense	2,162.05	
Exhibits and newspaper publicity	326.91	
Literature	2,462.87	
Postage	1,625.37	
Supplies	426.57	
Miscellaneous Activities	1,748.74	
Standing Committees:		
Auditing and Appropriations	780.00	
Public Relations and Economics	904.56	
Scientific Work	724.14	
Special Committees:		
Chronic Illness	182.03	
Industrial Health	353.48	
Maternal Health	786.38	
Military Advisory, Chairman, salary	3,000.00	
Miscellaneous	917.08	
Rural Health	2,608.35	
School Health	673.68	
Veterans' Affairs	1,272.45	
Annual Meeting	22,343.91	
Conference County Society Presidents-Secretaries	994.45	
Emergency and equipment fund	4,542.78	
Employees retirement fund	4,039.90	
Insurance and bonding	2,860.68	
Legal expense	8,790.89	
Postage	2,000.00	
Professional Relations Activities	5,297.79	
Rent and utilities	8,938.71	
Rural medical scholarships	2,000.00	
Stationery and supplies	4,183.79	
Telephone and telegraph	2,482.27	
Refunds: Banquet ticket	7.50	
Dues	40.00	
Total Disbursements		$208,553.04

Cash on Deposit and Bonds on Hand, December 31, 1956:

Huntington National Bank	$ 15,676.68	
Ohio National Bank (1957 dues)	36,300.00	
U. S. Treasury and Savings Bonds	90,000.00	
Total Cash and Bonds		$141,976.68
Total Accounted For (Includes 1957 Dues and Exhibit Payments Collected in Advance)		**$350,529.72**

THE OHIO STATE MEDICAL JOURNAL

ASSETS

Current Assets:

Cash in Ohio National Bank		$ 3,827.12
Petty Cash		20.00
Total Cash		$ 3,847.12
Accounts receivable: Advertising	$ 11,760.00	
Postage deposit	125.00	11,885.00
Total current assets		$ 15,732.12
Property Assets:		
Furniture and equipment (depreciated value)		14,882.91
Total Assets		**$ 30,615.03**

LIABILITIES AND SURPLUS

Surplus, December 31, 1955	$ 22,896.39	
Net income for year ended December 31, 1956	7,718.64	
Total surplus, December 31, 1956		$ 30,615.03

STATEMENT OF PROFIT AND LOSS

Income:

Advertising, gross		$ 60,445.14
Less: Commission on advertising	$ 5,308.38	
Cash discount on advertising	808.76	6,117.14
Advertising income, net		$ 54,328.00
Ohio State Medical Association appropriation		35,000.00
Subscriptions and sales		1,129.85
Ohio State Medical Association appropriation for typewriters and tables		871.34
Repayment of postage and supplies		160.28
Total net income		$ 91,489.47
Expenses:		
Salaries	$ 14,520.00	
Journal printing	63,006.71	
Journal postage	1,232.08	
Stationery, printing, and supplies	2,422.50	
Illustrations and engravings	341.63	
Travel expense	200.78	
Depreciation	1,607.74	
Miscellaneous postage	221.11	
Miscellaneous expense	221.28	
Total expenditures		$ 83,773.83
Surplus for the year		**$ 7,715.64**

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

Federal Civil Defense Agency has asked American Red Cross to prepare national emergency blueprint for collection and distribution of whole blood and to include in its home nursing course a special civil defense training that would qualify persons to work in treatment stations and civil defense hospitals.

* * *

Special Congressional subcommittee on safety was told by representative of Michigan State Medical Society that auto manufacturers are the only ones who can build safety factors into autos, and if they don't, Congress should enact a law forcing them to do so. Also, 1955 AMA resolution urging Congress to authorize a national body to approve and regulate auto safety standards was cited.

* * *

New committee of seven physicians to advise him on U. S. Public Health Service activities related to the practice of medicine has been appointed by Surgeon General Burney and has held its first meeting. Members include AMA trustees Hugh H. Hussey, Washington, D. C., and Julian Price, Florence, S. C.; Stuart Adler, Albuquerque, N. M.; C. Byron Blaisdell, Asbury Park, N. J., member, AMA Legislation Committee; W. L. Portteus, Franklin, Ind., past-president, IMA; Stanley R. Truman, Oakland, Calif., former president of AAGP, and William B. Walsh, Washington, D. C., past-president, National Medical Veterans Society.

* * *

Veterans Administration physicians engaged in cancer research are being aided by a unique movie. The movie shows in microscopic detail the death agonies of cancer cells.

* * *

Latest statistics on 11-year-old Hill-Burton program show 3,332 projects approved to date, with total estimated cost of $2,712,512,871; all but 301 are completed and in operation or under construction; total involves 146,947 hospital beds and 818 health centers.

* * *

New collaborative study on cerebral vascular disease is being launched by National Institute of Neurological Diseases and Blindness, with 10 medical research centers in nine states already given grants. Up to 40 institutions eventually will take part in study, expected to require five to six years for completion.

* * *

As of January, 1957, nation had 22,599,000 living veterans, 121,865 VA hospital beds with daily patient load averaging 111,540; for 1957 fiscal year, $619,614,000 will be spent by VA for in-patient care, $82,638,000 for out-patient care.

* * *

State Department has issued to World Health Organization invitation to hold 1958 WHO meeting in the U. S., with the host city yet to be determined. Invitation was issued despite uncertainty as to availability of $400,000 needed to plan the meeting and pay some of its expenses.

* * *

Internal Revenue Service has ruled sums received by a person under a Federal research grant are self-employment income and are taxable. Ruling held that "an individual who receives such payments for the purpose of conducting a research project free from direction or control of the grantor * * * or grantee institution is engaged in a trade or business as an independent contractor and the payments are includible in determining net earnings from self-employment.

* * *

American Council on Education has picked Arthur S. Flemming, Ph. D., president of Ohio Wesleyan University and recently resigned Federal Defense Mobilizer to direct a two-year, $400,000 study of dentistry in the United States. Sponsors are Kellogg Foundation and American Dental Association. Compares to Flexner study of 1908.

* * *

Consumer price index for February showed medical care at new peak, 135.5, retaining its top rank over food, housing, transportation and other essentials. Overall price index, based on 1947-49 base of 100, was 118.7.

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Woman's Auxiliary Annual Meeting Will Be Four-Day Event in Columbus, May 13-16

The Annual Meeting of the Woman's Auxiliary to the Ohio State Medical Association will be held at the Deshler-Hilton Hotel in Columbus on May 13, 14, 15 and 16 (Monday through Thursday) concurrently with the Annual Meeting of the OSMA, Mrs. William H. Evans, Youngstown, president, announced.

The Columbus Committee has laid plans for the programs and for special events. Mrs. George T. Harding, III, is convention chairman, and Mrs. Charles W. Pavey, convention co-chairman.

On Tuesday, May 14, there will be an Orientation Course and School of Instruction pertaining to "Who, Why, How and What Is the Auxiliary to the Ohio State Medical Association?" This will be followed by a tea and reception for all doctors' wives and their guests.

On Wednesday, May 15, "fun time" is planned for both husbands and wives. A luncheon is scheduled to start at noon in the Grand Ballroom of the Deshler-Hilton. This will be the "Doctors' Day" event and is planned so that it will not conflict with any of the OSMA sessions. Something extra special is planned for this event.

The afternoon session, in the words of the planning committee "will be one of the most interesting that has ever been planned." A humorous playlet titled "Doctor—This Is Your Wife," will be staged. This will be followed by the showing of colored slides of "Our Auxiliary in Action," with a fitting climax of "Talks in the Round Sessions."

On Thursday, May 16, the Auxiliary will honor the national president of the Woman's Auxiliary to the American Medical Association, Mrs. Robert Flanders. She will give an address and install the new officers. Luncheon will follow with a program.

Highlight of the convention will be the presentations of the following awards to the top counties in the state:

American Medical Education Foundation;

Today's Health;

Credits and Awards.

A $1,000 Scholarship will also be presented to a graduate nurse for postgraduate work. This fund has been made possible by contributions from the County Auxiliaries throughout the state.

Details of the program were published in the April issue of *The Journal*, page 456.

Film Available

"Even for One." This 27-minute dramatic film on the importance of a doctor's judgment has been prepared for television as a public service feature. For bookings, write AMA TV Film Library, 535 N. Dearborn St., Chicago 10, Ill.

Toledo Attorneys and Physicians Meet To Discuss Common Interests

An excellent example of how County Medical Societies are getting together with local Bar Associations to talk over common interests was demonstrated in Toledo recently.

Members of the Academy of Medicine of Toledo and Lucas County were hosts to members of the Toledo Bar Association on March 29 in the Academy Building.

Highlight of the program was the showing of the movie "The Medical Witness," a film that demonstrates right and wrong procedures in offering medical testimony in court.

Mr. Merritt Green, president of the Toledo Bar Association, and Dr. Schnitker, president of the Academy, gave brief remarks about the "Statement of Principles Governing Certain Physician-Lawyer Relationships." The statement has been approved by the Executive Committee of the Toledo Bar and the Council of the Academy of Medicine. Basically it is the same statement agreed upon between the Ohio State Medical Association and the Ohio Bar Association.

Interest shown in the subject was demonstrated by the fact that approximately 175 doctors and 175 lawyers filled the auditorium to capacity.

A social hour followed the program and discussion.

Dr. Blalock To Address Central Ohio Heart Ass'n. Meeting

The Central Ohio Heart Association has announced that it will have for its annual meeting speaker on May 24, Dr. Alfred Blalock, chief of the Department of Surgery, and surgeon-in-chief at Johns Hopkins University and Hospital, Baltimore.

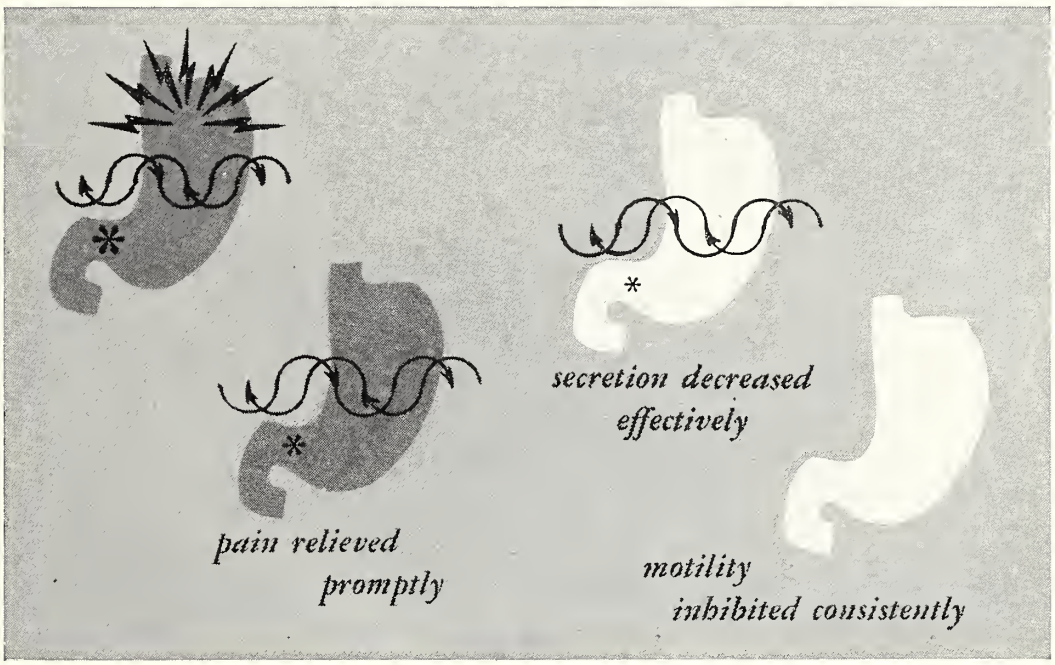
Dr. Blalock will speak on the subject, "Developments in Cardiac Surgery and Problems that Still Remain," at 8:00 p. m. on Friday, May 24 in the Ohio State Museum on the OSU Campus. Dr. Blalock is well known to the profession in the field of thoracic surgery. Among his contributions to cardiac surgery was his part in development of the operation to relieve stenosis in tetralogy of Fallot.

Other activities of the COHA annual meeting include conferences throughout the day of May 24. Additional information may be obtained from the office of the Central Ohio Heart Association, 50 E. Broad Street, Columbus.

A widened awareness of radiation hazards and control principles was urged by Dr. Elda E. Anderson in a talk at the University of Cincinnati. She is education and training section chief of the Oak Ridge National Laboratory's health physics division and the title of her talk was "Radiation Hazards and Current Practices in Radiation Protection."

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The therapeutic utility and effectiveness of Pro-Banthine in the treatment of peptic ulcer are repeatedly confirmed in the medical literature. Dosage: One tablet with each meal and two tablets at bedtime. G. D. Searle & Co., Chicago 80, Illinois, Research in the Service of Medicine.

*Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthine in the Treatment of Peptic Ulcer. A Clinical Evaluation with Gastric Secretory, Motility and Gastroscopic Studies. Report of 60 cases, Am. J. M. Sc. *232*:156 (Aug.) 1956.

SEARLE

In Memoriam . . .

Erl A. Baber, M. D., formerly of Cincinnati; University of Louisville School of Medicine, 1909; aged 73; died March 14 in Michigan where he was making his home since retirement; member of the Ohio State Medical Association, the American Medical Association and the American Psychiatric Association; diplomate of the American Board of Psychiatry and Neurology. Dr. Baber was superintendent of the Longview State Hospital in Cincinnati for 33 years before his retirement last year. He began his work in mental hygiene shortly after completing his medical education when he joined the Dayton State Hospital staff. He was superintendent there for 12 years before he went to Longview. Dr. Baber was clinical professor of psychiatry at the University of Cincinnati. During World War II he served with the Army Medical Corps as lieutenant colonel. He was active in the Masonic Lodge, the Boy Scout work, the Rotary Club of which he was past-president and former district governor, the Cincinnati Sailing Club, Torch Club, Travel Club and Literary Club. Surviving are his widow, a daughter and a son.

Nelson A. Brandeberry, M.D., Springfield; Western Reserve University School of Medicine, 1930; aged 54; died March 22; member of the Ohio State Medical Association and the American Medical Association. A native of Athens, Ohio, Dr. Brandeberry had practiced in Springfield since 1935 with four and a half years break for service with the Medical Corps attached to the Air Force during World War II. In 1950 he was head of the medical staff at Springfield City Hospital. He was a member of the medical staff of Mercy Hospital also. Survivors include his widow, three daughters, his father and a brother.

Wendel P. Brown, M. D., Wyoming and Lockland; Eclectic Medical College, Cincinnati, 1912; aged 75; died March 21; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Brown had been a practicing physician in the Greater Cincinnati area for 38 years. Survivors include his widow, a daughter, two sons and three brothers.

Kendall O. Burns, M. D., Lima; Indiana University School of Medicine, 1951; aged 32; died March 27 when his car collided with a railroad train; member of the Ohio State Medical Association and the American Medical Association. Living in Lima for 2½ years, Dr. Burns was resident physician at Memorial Hospital before he entered practice. He had previously done residency work at Huron Road Hospital in Cleveland and at Akron City Hospital. Affiliations included memberships in the Presbyterian Church and the Masonic Lodge. Survivors include his widow, a son and his parents.

Paul I. Carman, M. D., Cincinnati; University of Minnesota Medical School, 1915; aged 67; died March 22. A former practicing physician in St. Paul, Minn., Dr. Carman retired in 1940 and moved to Cincinnati. His widow survives.

Patrick Charles Doran, M. D., Akron; Western Reserve University School of Medicine, 1929; aged 55; died March 21; member of the Ohio State Medical Association, the American Medical Association, the Clinical Orthopedic Society, American Academy of Orthopedic Surgeons, Fellow of the American College of Surgeons; diplomate of the American Board of Orthopedic Surgery. A native of Akron, Dr. Doran practiced there for 25 years. He served four years with the Army Medical Corps during World War II and was discharged as lieutenant colonel. He was a member of the Akron City Club, University Club, the Catholic Church, Knights of Columbus and Holy Name Society. Survivors include his widow, two sons three daughters and two sisters.

Clyde M. Dummer, M. D., Cincinnati; University of Cincinnati College of Medicine, 1934; aged 53; died March 9; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Pediatrics. A practicing physician in Cincinnati since 1933, Dr. Dummer was on the faculty of the University of Cincinnati. He was on the staff of Children's Hospital and other Cincinnati Hospitals. Survivors include his widow and a daughter.

Warren J. Howard, M. D., Waitsfield, Vermont; University of Vermont College of Medicine, 1906; aged 80; died March 19; member of the Ohio State Medical Association through 1949. A former practicing physician in Toledo for many years, Dr. Howard recently was awarded the 50-Year Pin of the OSMA. He retired about seven years ago and moved to Vermont. Surviving are his widow, a daughter and a sister.

Mark Walton Jacoby, M. D., Cleveland; Ohio State University College of Medicine, 1917; aged 64; died March 28; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Ophthalmology and Oto-Laryngology; diplomate of the American Board of Ophthalmology. Dr. Jacoby practiced for a short time in New London before he moved to Cleveland as head of the medical department of the General Electric Company. After 13 years with that organization he went into private practice. He was director of the Department of Ophthalmology at St. Luke's Hospital. Surviving are his widow and a son.

Curt Kayser, M. D., Cleveland; medical degree from Friedrich Wilhelms University, Germany, 1910; aged 71; died March 5; was a member of the Ohio State Medical Association, the Amer-

Ohio Physician Is Featured on "This Is Your Life" Program

Dr. George H. Gale, physician of Newport in Washington County, was guest on the Ralph Edwards' "This Is Your Life" television show originating in Hollywood on March 20.

An excellent article on the Gale family was written by Helen M. White, of Lowell, and appeared in the *Columbus Dispatch* of March 17. She did much of the research work for the life sketch. Dr. George Gale began his practice in the community in 1908, following in the footsteps of his father and grandfather. His son, Dr. Larrey Bernard Gale, began practice with his father in 1950, and became the fourth generation of the Gale physicians to practice in Newport and area.

In 1819, Dr. George Washington Gale came west and settled at Willow Island, then in Virginia but now West Virginia. Two years later he moved a few miles up river on the Ohio side to Newport. At that time the only doctor in the area, his practice extended from Moundsville to Marietta.

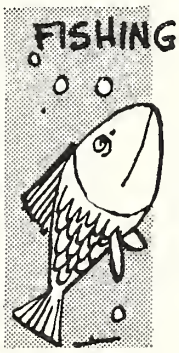
The second generation physician was Dr. George Thomas Gale who graduated from Jefferson Medical College in 1864. He retired in 1935 after 61 years of practice and lived to the age of 94.

Dr. Gale went to Hollywood ostensibly to see his wife take part in another program.

Ohio State Radiological Society To Meet in Dayton May 24-26

The Annual Meeting of the Ohio State Radiological Society is scheduled to be held in Dayton, at the Van Cleve Hotel, Friday, Saturday and Sunday, May 24, 25 and 26, according to an announcement from Dr. John R. Hannan, secretary.

Dr. Donald W. English, Lima, president of the organization, will preside over business sessions. An excellent program has been arranged for those who attend. Additional information may be obtained from the secretary at 10515 Carnegie Ave., Cleveland 6, Ohio.



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EYE, EAR, NOSE, AND THROAT

A three months combined full time refresher course consisting of attendance at clinics, witnessing operations, lectures, demonstration of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; clinical and cadaver demonstrations in bronchoscopy, laryngeal surgery and surgery for facial palsy; refraction; radiology; pathology, bacteriology and embryology; physiology; neuro-anatomy; anesthesiology; physical medicine; allergy, as applied to clinical practice. Examination of patients preoperatively and follow-up post operatively in the wards and clinics. Attendance at departmental and general conferences.

UROLOGY

A combined full time course in Urology, covering an academic year (8 months). It comprises instruction in pharmacology; physiology; embryology; biochemistry; bacteriology and pathology; practical work in surgical anatomy and urological operative procedures on the cadaver; regional and general anesthesia (cadaver); office gynecology; proctological diagnosis; the use of the Ophthalmoscope; physical diagnosis; roentgenological interpretation; electrocardiographic interpretation; dermatology and syphilology; neurology; physical medicine; continuous instruction in cystoendoscopic diagnosis and operative instrumental manipulation; operative surgical clinics; demonstrations in the operative instrumental management of bladder tumors and other vesical lesions as well as prostatic resection.

PROCTOLOGY AND GASTROENTEROLOGY

A combined course comprising attendance at clinics and lectures; instruction in examination, diagnosis and treatment; pathology, radiology, anatomy, operative proctology on the cadaver, anesthesiology, witnessing of operations, examination of patients preoperatively and postoperatively in the wards and clinics; attendance at departmental and general conferences.

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ican Medical Association and the American Academy of General Practice. A former practicing physician in Germany, Dr. Kayser was licensed to practice in Ohio in 1939 and had been a practicing physician in Cleveland for a number of years.

Jamison C. Mills, M. D., Toledo; Maharry Medical College, Nashville, Tenn., 1916; aged 64; died March 8. Dr. Mills had been a practicing physician in Toledo for 30 years. He is survived by a daughter, three brothers and three sisters.

Olney B. Monosmith, M. D., Lorain; University of Illinois College of Medicine, 1893; aged 85; died March 8; former member of the Ohio State Medical Association and the American Medical Association; member of the American Academy of Ophthalmology and Oto-Laryngology; Fellow of the American College of Surgeons; diplomate of the American Board of Ophthalmology. A native of Lorain County, Dr. Monosmith practiced there over a period of 63 years, with time out for postgraduate studies. He did graduate work in Chicago and New York, at Harvard and in Europe. Dr. Monosmith was a past-president of the Rotary Club, a member of the Lorain Country Club and several Masonic bodies. Survivors include his widow, two daughters and two brothers.

Frank R. Schirripa, M. D., Cleveland; Stritch School of Medicine of Loyola University, 1934; aged 51; died March 12; member of the Ohio State Medical Association. A native of Cleveland, Dr. Schirripa practiced there on the West Side for more than 20 years. He was a veteran of World War II, having served as major with the Army Medical Corps. Affiliations included memberships in the Knights of Columbus, the Catholic Church, and the American Legion. Survivors include his widow, a son, a daughter, a brother and three sisters.

Richard B. Shelton, M. D., Columbus; Medical College of Ohio, Cincinnati, 1903; aged 81; died February 24; former member of the Ohio State Medical Association. A native of south-central Ohio, Dr. Shelton practiced in Georgetown and vicinity for more than a half century before his retirement in 1954. He had been honored with the 50-Year Pin of the Ohio State Medical Association. Surviving are a daughter with whom he resided in Columbus after his retirement, and two sons.

Reo M. Swan, M. D., Cambridge; Rush Medical College, 1932; aged 54; died March 7; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Swan was a practicing physician for 25 years in Cambridge where he was associated with his brother, Dr. George F. Swan in the operation of the former Swan Hospital. In recent years he was chief of staff at Guernsey Memorial Hospital. Prominent in cultural, civic and educational affairs of the community, he was a member of the Methodist Church and several Masonic bodies. Survivors include his widow; two sons, Dr. Thomas D. Swan and Dr. George R. Swan; two brothers, Dr. George F. Swan of Cambridge, and Dr. John R. Swan of Indianapolis; also a sister.

Louis Earl Wharton, M. D., Akron; University of Pennsylvania School of Medicine, 1920; aged 66; died March 28; member of the Ohio State Medical Association and the American Medical Association. Dr. Wharton was a practicing physician in Akron for about 37 years. He was a veteran of World War I, and a member of the Masonic Lodge. Surviving are a son, Dr. Earl W. Wharton of Akron, a daughter, two brothers and two sisters.

Theodore Zbinden, M. D., Toledo; University of Michigan Medical School, 1901; aged 79; died March 19; member of the Ohio State Medical Association, the American Medical Association, the College of American Pathologists and Fellow of the American College of Physicians; diplomate of the American Board of Pathology. Dr. Zbinden served all of his professional career in Toledo with time out for graduate studies. For 25 years was pathologist for the Flower Hospital. Active in a number of organizations in addition to his professional work, he was a member of the Lions Club, the Masonic Lodge, and served four years on the Toledo Board of Education. An accomplished musician he was active for many years with the Orpheus Choral Society. Surviving are his widow, a son, a daughter and two brothers.

Statistics Given for Mortality During the Past Year

All-time low death rates were recorded in 1956 for tuberculosis, maternity, the childhood diseases, suicide, and homicide, the statisticians of the Metropolitan Life Insurance Company reported.

In addition, the poliomyelitis death rate dropped to half that for 1955—or to only .3 per 100,000.

Mortality from all causes continued at the record low level of the two preceding years.

Since 1911 the death rate in this group has been reduced about one-half, the statisticians point out; and when allowance is made for the increase in the average age of these insured persons, the improvement is about two-thirds.

The cardiovascular-renal diseases accounted for a little over half the total deaths in 1956. Second in rank were cancer and allied conditions, responsible for slightly more than one-fifth of the deaths. Accidents ranked third, and these three causes of death added together accounted for four-fifths of all the deaths.

The death rate from cancer (all forms) was 128.7 per 100,000, compared with 128.2 in 1955; for respiratory cancer, it rose from 16.5 to 17.5 per 100,000. The death rate from diabetes was almost identical in the two years, as was that from pneumonia.

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We appreciate the wonderful reception the doctors accorded us at the Ohio State Medical Association meeting in Cleveland last year, and at the Ohio Academy of General Practice meeting in Columbus in September. If you missed our exhibits at these meetings, we invite you to stop and see us at the Ohio State Medical Association 1957 Annual Meeting in Columbus in May and discuss your investment problems with us.

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Activities of County Societies . . .

First District

(COUNCILOR: FRANK H. MAYFIELD, M. D., CINCINNATI)

CLERMONT

The Clermont County Medical Society met on April 17 at the DX Ranch with Dr. Schultze as host. Speaker for the occasion was Dr. Charles K. Ferguson, whose subject was, "Menstrual Dysfunction."

HAMILTON

Guest speaker for the April 2 meeting of the Academy of Medicine Cincinnati was Dr. Howard B. Burchell, professor of medicine, Mayo Foundation Graduate School of Medicine, University of Minnesota and consultant at the Mayo Clinic. This was a joint meeting with the Heart Council. Dr. Burchell's topic was "Diagnosis of Unusual Forms of Heart Disease."

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

CLARK

Col. George O. Emerson, M. D., and Major Stanley White, M. D., of the Aero-Medical Center, Wright-Patterson Air Force Base, presented an illustrated lecture on "Aero Medical Problems in High Speed, High Altitude Flight" at the March 18 meeting of the Clark County Medical Society.

Their presentation was illustrated with film slides and a motion picture concerning the role oxygen plays in making it possible for pilots to fly high speed, high altitude aircraft.

At the same meeting, the membership adopted two resolutions, one to Loren G. Schultz, city editor of *The Springfield Daily News* and *The Sunday News-Sun*, and the other to those newspapers and *The Springfield Sun*, commending Mr. Schultz, the newspapers and their editorial staffs for "displaying the highest principles of the profession of journalism" throughout publication of news concerning medicine, medical societies and general health.

DARKE

The regular monthly meeting of the Darke County Medical Society was held at the Treaty City White Shrine Temple in Greenville on March 19. Speaker was Dr. Philip A. Weisman, Dayton, whose subject was "Initial Treatment of Minor Lacerations."

MIAMI

Dr. John Holzaepfel, of the Department of Obstetrics and Gynecology, Ohio State University, was guest at the April 5 meeting of the Miami County Medical Society. His subject was "Office Gynecology." The meeting was held at the Dettmer Hospital, Troy, followed by dinner.

MONTGOMERY

The Dayton Surgical Society met on March 26 at the Van Cleve Hotel for dinner followed by a program. The speaker was Dr. W. R. Culbertson, instructor in surgery at the University of Cincinnati, whose topic was "Studies in Experimental Irreversible Hemorrhagic Shock."

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The April schedule of the Academy of Medicine of Toledo and Lucas County contained the following features:

April 5, General Section, "Intern-Resident Program" being a presentation of papers by house staff members.

April 11, 84th Annual Meeting of the Northern Tri-State Medical Association in the Academy Building.

April 26, Surgical Section, "The Problems of the Acute Abdomen in Infants and Children," by Dr. Clifford D. Benson, associate professor, Wayne University Medical School.

The March 29 meeting which was a joint program with the Toledo Bar is reported elsewhere in this issue.

The Medical Veterans Society annual dinner was held on April 4 at the Secor Hotel. The speaker was Dr. T. Christie Innes, pastor of the Collingwood Presbyterian Church, who spoke on the subject, "Vital Matters in the Middle East Area."

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

CUYAHOGA

The meeting of the Academy of Medicine of Cleveland and Cuyahoga County on April 19 included the following features:

"The Theories Concerning the Etiology of Chronic Recurrent Pancreatitis," Dr. George H. A. Clowes.

"The Clinical Picture and Diagnosis of Chronic Recurrent Pancreatitis," Dr. Norman W. Thiessen.

"The Treatment of Chronic Recurrent Pancreatitis by Sphincterotomy, Sympathectomy and Splanchnicectomy," Dr. Stanley Hoerr.

"The Individualized Surgical Treatment of Chronic Recurrent Pancreatitis," Dr. Philip F. Partington.

A panel discussion followed with Dr. Partington as moderator.

The foregoing program features were held in

the late afternoon. The evening program featured a discussion on the subject, "Chronic Relepasing Pancreatitis," by Dr. Samuel R. Powers, professor of experimental surgery, Albany Medical College, Albany, N. Y.

A newly formed Academy Golf Association was announced with an initial membership of 115 members, and a tournament was scheduled for the Lake Forest Country Club on July 18. This event will be the first Academy tournament since the late 1940's.

Specialty section meetings were scheduled as follows during April:

Experimental Medicine Section and Cleveland Section of the Society for Experimental Biology and Medicine, April 22.

Section on Anesthesiology, April 17.

Section on Surgery of Trauma, April 12.

The Cleveland Academy of Medicine in cooperation with the Cleveland Center on Alcoholism presented a day long symposium on the subject of alcoholism at St. Luke's Hospital, Cleveland, on April 17 for the Ohio Academy of General Practice.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

STARK

The Stark County Medical Society met on April 12 in the Belden Hotel, Canton, for a program. The speaker was the Hon. Frank T. Bow, Congressman for the 16th District, whose subject was "Medical Legislative Affairs."

Coming events in the Stark County calendar are the annual picnic to be held at Congress Lake Country Club on May 29, and the annual stag golf tournament scheduled for June 19 at the Alliance Country Club.

SUMMIT

"How the Coroner's Functions Affect Public Health of the Community," was the subject discussed at the April 2 dinner meeting of the Summit County Medical Society. The speaker was Dr. S. R. Gerber, Cleveland, coroner of Cuyahoga County. Dinner was at the Akron City Club, followed by the program at the Akron General Hospital Auditorium.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

The Belmont County Medical Society held its monthly meeting on March 21 at the Belmont Hills Country Club. Following the business session, C. C. Grubbs, deputy claims administrator of the Ohio Bureau of Workmen's Compensation, spoke on the subject, "Problems Pertaining to the Bureau of Workmen's Compensation." Following the program the Medical Society joined the Auxiliary for dinner.

The April 18 meeting of the Society was held at the Bellaire City Hospital with the hospital staff presenting the program under chairmanship of Dr. D. M. Creamer. Dinner followed the afternoon session.

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D., LANCASTER)

GUERNSEY

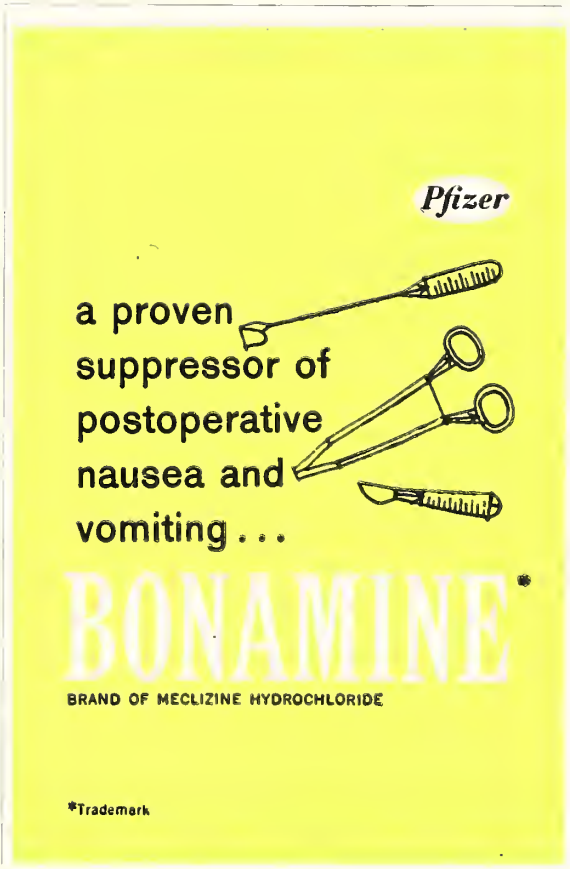
Following is a resolution endorsed by the Guernsey County Medical Society at its meeting on April 4:

RESOLUTION

Dr. Reo M. Swan was born May 17, 1902, near Boden in Knox Township, Guernsey County, Ohio, the son of Mr. and Mrs. Thomas K. Swan, early and most highly respected citizens in that community who endeared themselves to their neighbors with kindness and help in times of adversity.

WHEREAS, Dr. Reo M. Swan was a kind man,

(Continued on Page 598)



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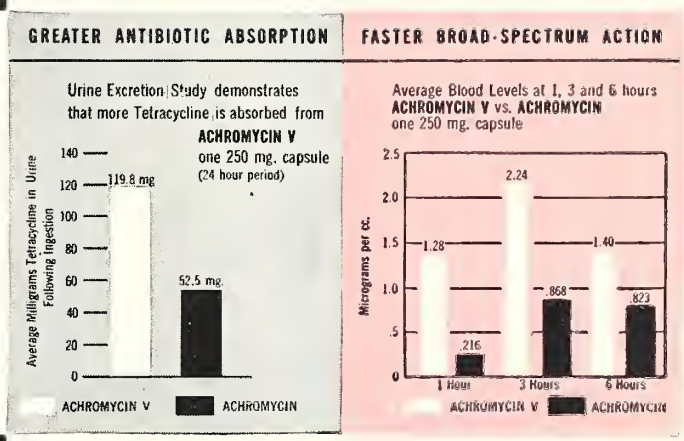
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with sympathy for his patients, and for people in general.

And WHEREAS, He supported every worthwhile enterprise for the good of the community and his fellow man.

And WHEREAS, He was a loving husband and a kind and indulgent father.

And WHEREAS, His qualifications as a physician and surgeon were the very highest. His devotion to his profession in ethics and skill was unsurpassed. His judgment was sound. His contribution to the science of medicine was valuable, and far above that made by the average physician. His procedures and technique were in line with the latest and most approved methods.

And WHEREAS, His services to the public, to his associates in the Medical Society of which he was a member, will be sadly and sorrowfully missed. He leaves a place in the hearts and homes of the people of Guernsey County that cannot be filled. His place in the deliberations and councils of the medical profession is a very serious loss.

THEREFORE BE IT RESOLVED by the members of the Guernsey County Medical Society: that they extend their heartfelt sympathy to his wife, Mary Ruth DeSelm Swan, to his family and friends. We commend Dr. Reo M. Swan for his many virtues, his religious character, his very many high qualifications as a gentleman and leader in the community.

FURTHER BE IT RESOLVED, That a copy of these resolutions be spread on the minutes of the proceeding of the Guernsey County Medical Society, a copy to his wife and family, a copy to his brothers, Dr. George F. Swan and Dr. Raymond Swan, a copy to his sister, Mrs. Della McCall and a copy published in *The Ohio State Medical Journal*.

Respectfully submitted by the
Committee on Resolutions,
Henry L. Wells, M. D.
W. L. Denny, M. D.
F. Gordon Lawyer, M. D.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

The quarterly meeting of the Columbus Academy of Medicine was held in the Southern Hotel, Columbus, on March 21, with an afternoon program, dinner and after-dinner program.

The subject of the afternoon program was "Tax Considerations in Estate Planning," with Joseph McElligott as speaker. Mr. McElligott is a business and tax consultant with offices in New York City. He was with the Bureau of Internal Revenue for 14 years and for the past eight years has operated a business consultant organization

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Dr. Thomas A. Alphin, director of the Washington Office of the AMA, was the evening speaker and discussed the subject, "Newer Matters of Legislation."

ROSS

The regular meeting of the Ross County Medical Society was held on April 4 at the Colonial Inn. There were 28 members and one guest present.

The meeting was opened by President Charles Hoyt.

Dr. Edwin H. Artman, Councilor of the Tenth District and a member of the society, reported for the Legislative Committee. He presented a resolution which was passed, thanking State Representative David Phillips for supporting the views of the Society on the Chiropractor Bill. Dr. Artman also commented on House Bill 384, the bill for furthering medical research. The Society voted to approve the bill and authorized a letter informing the state representative of this action.

Dr. Hoyt reported for the Health Committee concerning the proposed immunization program to be carried out under the auspices of the Board of Health. Following discussion, a procedure for carrying out the program was approved.

Dr. Holmes discussed the subject of public subscriptions for uniforms for the Chillicothe High School Band. The society reaffirmed its principle of not contributing to a charitable fund as an organization but leave it up to individual members to contribute. During the discussion, it was brought out that the Society should endorse charitable drives and should encourage individual members to make individual contributions.

It was announced that a meeting of the South Central Ohio Academy of General Practice would follow the Society meeting.

Dr. Swank then introduced Dr. Jay Jacoby, chief of the Department of Anesthesia of the University Hospital, Columbus. Dr. Jacoby gave an interesting discussion of anesthesia. A profound and prolonged question and answer period followed.—Lewis W. Coppel, M. D., Secretary.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

RICHLAND

Members of the Richland County Medical Society met at the Mansfield General Hospital, Thursday, March 21, 1957.

Following dinner, which was served at the hospital, a business meeting was held with Dr. Harry Wain presiding as President.

Presenting the program was Geo. J. Hamwi, M. D., Associate Professor of Medicine at Ohio State University. His subject was: "Endocrinology for the General Practitioner."

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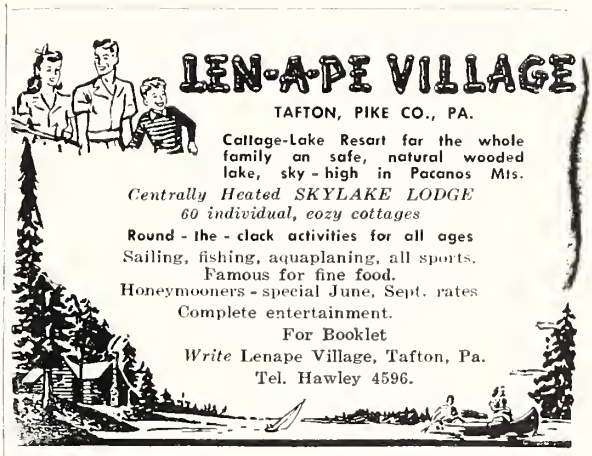
The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

January 29, 1957—George Everett Files, Gallipolis, George Washington University.

April 2, 1957—Andrew Jackson Barger, II, Jefferson Medical College; George Edward Baujan, Dayton, St. Louis University; Paul D. Balstad, Columbus, Univ. of Michigan; Richard B. Belt, Mansfield, Univ. of Oregon; Robert Barrett Bird, Canton, Univ. of Illinois; Robert Louis Bratman, Cleveland, Univ. of Illinois;

Clarence Edgar Carnahan, Jr., Columbus, College of Medical Evangelists; John Henry Coleman, Springfield, Indiana University; Walter Robbin deForest, Hamilton, Columbia Univ.; Frederick Norton Dickman, Jr., Cleveland, Louisiana State Univ.; Quentin Lane Erd, Dayton, Indiana Univ.; Thomas Mitchell File, Columbus, St. Louis Univ.; Edwin Matthew Goyette, East Cleveland,

(Continued on Page 600)



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Theodore Franklin Haase, Jr., Toledo, Univ. of Tennessee; John Joseph Harrington, Jr., Lorain, Tufts College; John P. Hill, Lima, Northwestern University; Donovan F. Hinchman, Warren, Univ. of Michigan; Walter D. Hofmann, Worthington, College of Medical Evangelists; Donald R. Holsinger, Columbus, Medical College of Virginia; Robert J. Hummel, Knollwood, St. Louis Univ.;

Richard M. Inglis, Toledo, St. Louis Univ.; Robert E. Kennedy, Cincinnati, Yale University; Mark G. Konrad, Univ. of Louisville; Norloso B. Livingston, Jr., Columbus, Temple Univ.; William H. Luginbuhl, Cleveland, Northwestern Univ.;

John H. Marsh, Bowling Green, Univ. of Buffalo; William V. Martinez, Cleveland, Jefferson Medical College; Elizabeth Jean McGavran, Akron, Washington Univ.; Clifford D. Molzahn, Cleveland, Univ. of Minnesota; Nizar N. Oweida, Fairborn, American Univ. of Beirut;

Henry Paul, Dayton, Howard University; Charles W. Petenyi, Univ. of Budapest; Gerald M. Platock, Cleveland, Medical College of Georgia; John L. Pruzzo, Dayton, St. Louis Univ.; Victor E. Reinking, Cleveland, Univ. of Kansas; Joseph H. Richardson, Cleveland, Northwestern; Frank N. Ritter, Toledo, St. Louis Univ.; Malcolm L. Robbins, Columbus, Univ. of Maryland; Ralph L. Rutledge, Jr., Alliance, Harvard Medical School;

Thomas Scarlett, Akron, Temple Univ.; Donald A. Senhauser, Dover, Columbia Univ.; Aldona Slupas, Woman's Medical College of Pennsylvania; Herbert Sohn, Cleveland, The Chicago Medical School; Melmoth Y. Stokes, III, Edon, Southwestern Medical School; Thomas D. Swan, Cambridge, Northwestern Univ.;

F. Douglas Travis, Dayton, Dalhousie Univ.; William H. Waller, Columbus, Univ. of Georgia; Wilfred H. Weltge, Dayton, Washington Univ.; David P. Wheeler, Toledo, Univ. of Michigan; Howard S. Yaffee, Columbus, Harvard Medical School.

Two Ohioans Named Trustees of Student AMA Foundation

Twenty-four persons prominent in the fields of medicine, education and industry have been named as honorary trustees of the Foundation of the Student American Medical Association, according to Russell F. Staudacher, Chicago, Foundation secretary. Among them are Dr. Edward J. McCormick, Toledo, past-president of the AMA; and Faustin J. Solon, vice-president of the Owens-Illinois Company, also of Toledo.

The organization was founded in 1955 as an irrevocable trust to give financial aid to growing numbers of medical students in their last three years of training. Initial appeal for support is being directed to all medical organizations, individual physicians, pharmaceutical manufacturers and philanthropic groups.

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GYNECOLOGY—Office & Operative Gynecology, two weeks, June 17. Vaginal Approach to Pelvic Surgery, one week, June 10.

MEDICINE—Electrocardiography & Heart Disease, two-week basic course, July 8. Hematology, one week, June 17.

RADIOLOGY—Diagnostic X-Ray, Clinical Course, by appointment. Radium Therapy, one week, June 24.

CYSTOSCOPY—Ten Day Practical Course by appointment.

PEDIATRICS—Neuromuscular Diseases; Cerebral Palsy, July 8.

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Activities of Woman's Auxiliary . . .

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President—Mrs. William H. Evans, 291 Park Ave., Youngstown
President-Elect—Mrs. V. R. Frederick, 145 Tanglewood Dr., Urbana
Vice-President: 1—Mrs. C. H. Bell, Mansfield
2—Mrs. W. R. Gibson, Oak Harbor
3—Mrs. C. A. Colombi, Cleveland
Recording Secretary—Mrs. Lester W. Sontag, Livermore St., Yellow Springs
Corresponding Secretary—Mrs. Earl Young, 170 Brookline Ave., Youngstown
Past-President and Finance Chairman—Mrs. Karl Ritter, 1420 Shawnee Rd., Lima

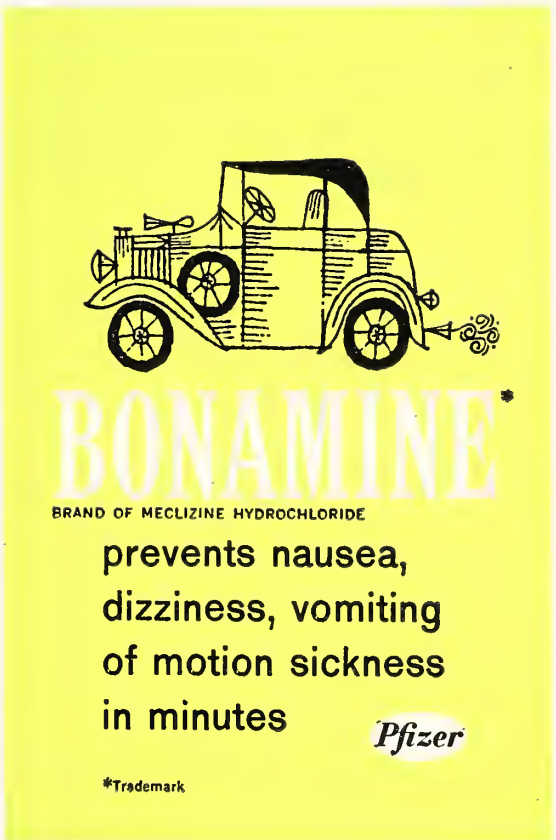
ALLEN

Mrs. James R. Fletcher entertained members of the Auxiliary to the Lima and Allen County Academy of Medicine, and their guests, with an interpretation of the current hit Broadway musical, "My Fair Lady," on March 26.

The occasion was the Auxiliary's annual guest luncheon, held in the Plantation of the Elks Home.

Mrs. R. P. Epstein, president, conducted the business session and announced two nurse recruitment teas to be sponsored by the Auxiliary.

Serving as hostesses for the guest party were Mrs. R. G. Hendershot, Mrs. D. L. Becker, Mrs. M. M. Sondheimer and Mrs. E. B. Young.



CHAMPAIGN

The Woman's Auxiliary to the Champaign County Medical Society met March 1 at the Urbana Country Club for its monthly meeting. The guest speaker was Mrs. Ross Greenawalt, from Springfield, who gave an interesting account of her recent trip to Europe and the Near East. Mrs. William Putnam, program chairman, and Mrs. T. E. Richards made arrangements for this affair.

CLARK

A dinner held March 11 in the Shawnee Hotel honored the husbands of members of the Clark County Medical Society's Auxiliary. This was the group's annual observance of "Doctor's Day."

Dr. and Mrs. Nicholas Pavlatos presented a travelogue of colored slides of their recent trip to Europe.

The committee in charge of arrangements included Mrs. William Crays, Mrs. John Davidson, Mrs. William Allison, Mrs. E. H. Winterhoff, Mrs. M. J. Cook and Mrs. Robert Horton.

COSHOCTON

Dr. Arthur R. Hopwood, superintendent of the Cambridge State Hospital was the speaker when the Woman's Auxiliary to the Coshocton Medical Society met with Mrs. G. A. Foster, Coshocton, on March 12. Dr. Hopwood gave an informative talk on mental health and on the state hospital at Cambridge.

The program headlined the American Medical Education Foundation and featured the movie, "Danger at the Source." This program was held as a preliminary to American Medical Education Week.

Mrs. William Pfaadt, president, welcomed the members and guests, who were representatives of the Area's 15 federated clubs.

FAIRFIELD

Junior and Senior High School girls interested in a nursing career were entertained with a tea on March 8 given by the Woman's Auxiliary to the Fairfield County Medical Society. Each spring the Auxiliary assisted by the nursing staff and the student nurses, entertains girls interested in becoming nurses.

Mrs. James Beesley and Mrs. Andrew Essman were general co-chairmen.

FRANKLIN

More than 80 members of the Columbus Academy of Medicine helped staff clinics during Immunization Week in Columbus. The doctor's wives did the clerical work. Mrs. Jack Silberstein was chairman of the group. Her aides were Mrs. George Hummel, Mrs. Jay Jacoby, Mrs. Francis Gallagher and Mrs. Walter Baum.

HARDIN

The Hardin County Medical Auxiliary was

hostess on March 21 to 73 high school pupils of the county who registered for the annual Hospital Career Day tea held at Hardin Memorial Hospital.

The Auxiliary arranged for a tour of the various departments of the hospital, and for speakers to advise the girls about the technical aspects.

Mrs. Robert Zeis and Mrs. Stephen Churchill were co-chairmen in charge of arrangements for the yearly tea.

LUCAS

The Woman's Auxiliary to the Academy of Medicine of Lucas County held a bridge luncheon at the Academy Building on March 26. The proceeds were for the American Medical Association Education Foundation. Mrs. Elaine Woodward and Mrs. Nancy Rank were co-chairmen of the affair.

DARKE

Members of the Darke County Medical Auxiliary sponsored an essay contest of the American Association of Physicians and Surgeons. Miss Peggy Haag, a Greeneville High School Sophomore was selected the winner: her topic was "The Advantages of Private Medical Care." Her essay will be submitted to the AAPS for national competition.

MAHONING

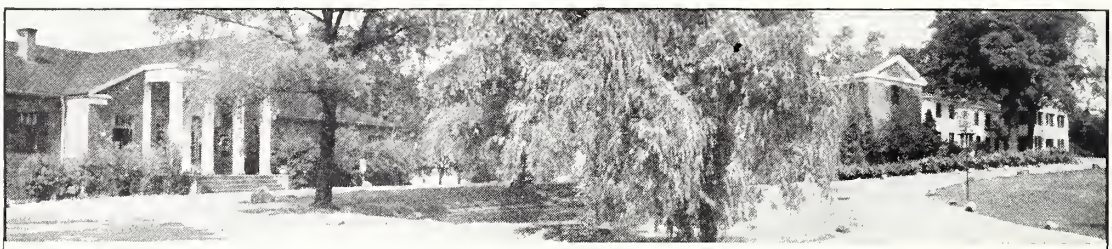
The Woman's Auxiliary to the Mahoning County Medical Society and the Auxiliary to the Mahoning Valley Professional Engineers held a joint dinner meeting on March 19 at the Hotel Pick-Ohio. Mrs. Ivan C. Smith was chairman for the occasion. Mrs. James N. Gordon and Mrs. Andrew A. Detesco were co-chairmen.

Mr. Jack Miller, chief social worker of the Child Guidance Center, presented an interesting program on mental health.

OTTAWA

Following are excerpts from an editorial published in the *Port Clinton Herald and Republican* paper March 1: "Going about its business in an unpretentious manner, seeking no praise and shunning the limelight, is an organization known as the Auxiliary to the Ottawa County Medical Association . . . Behind it all is a group of women who have a common purpose in bettering the health of every individual. As companions to their doctor-husbands, they are ever on the alert to lend their aid.

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their husbands, they are no publicity seekers. They prefer to give of their work in a quiet and unassuming manner . . ."

RICHLAND

What the Richland County Medical Society is doing about civilian defense was the topic Mrs. Harry Wain chose for her discussion at the Auxiliary meeting held on March 4 at the Women's Club.

The Auxiliary voted to buy pins for members of the Future Nurses Club of which they are sponsors.

Hostesses for the meeting were Mrs. Wendell Bell, Mrs. Carroll Damron, Mrs. Alvin Bales, Mrs. Robert Peirce and Mrs. Walter Massic.

ROSS

The Woman's Auxiliary to the Ross County Academy of Medicine had a business session and style show following luncheon on March 6 at the Lynne House. Mrs. Lewis Coppel presided and welcomed a new member, Mrs. Joseph Scott McKell. Mrs. John Franklin, Jr., and Mrs. Robert Quinn were in charge of arrangements.

TUSCARAWAS

Dr. C. Raymond Crawley, of Dennison, presented an interesting talk on "Hypnosis in Medicine" when members of the Woman's Auxiliary to the Tuscarawas County Medical Society met on March 14. Dr. Crawley explained how hypnosis is used to allay fear, tension and pain in making a patient more cooperative and at ease in certain types of illness.

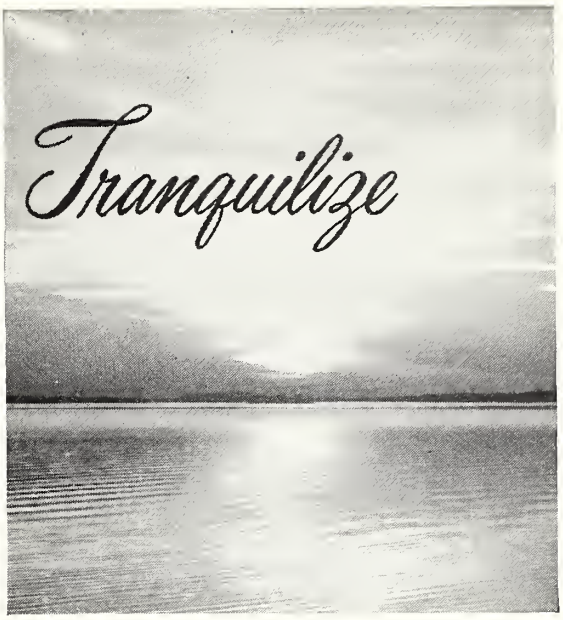
The meeting was held in the home of Mrs. P. T. Doughten, with Mrs. George Woodward, Mrs. H. A. Coleman, Mrs. C. J. Miller and Mrs. C. M. Dougherty assisting the hostess.

It Pays To Be Married, Mortality Statistics Indicate

The married have an advantage as to mortality at every period of life, particularly prior to age 45, according to Metropolitan Life statisticians. Among males at ages 20-44, for example, the death rate for the married is only about half that for the single, and an even smaller fraction of the rate for the widowed or divorced.

Among men, several causes of death show markedly higher mortality among the unmarried than the married. The tuberculosis death rate is four times as high. The death rate from influenza and pneumonia is 2½ times as high among widowers, and the single and divorced are at even greater disadvantage.

Accidents also take a relatively higher toll among unmarried men. At ages 20-44 the motor vehicle accident death rate is four times as high for widowers and divorced men as for the married.



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New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since March 1, 1957. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ALLEN COUNTY

Theodore J. Reshetylo, Lima

BUTLER COUNTY

William F. Harding, Hamilton
H. Sheffield Jeck, Jr., Oxford

CLARK COUNTY

Bernard J. Begley, Springfield
George G. Cornish, Yellow Springs

CUYAHOGA COUNTY

Marc Balin, Willoughby
George H. Brown, Cleveland
John H. Campbell, Cleveland
James R. Coy, Bay Village
Leo T. Delaney, Jr., Cleveland
William J. Duhigg, Cleveland
Patricia A. Foust, Cleveland
Mary Clare Harman, Cleveland
William J. Keating, Cleveland
Abraham Klar, Cleveland
Vilis Kruze, Cleveland
Paul G. Koussandianos, Cleveland
Donald S. Linton, Jr., Cleveland
Charles Long, II, Cleveland
Harrison O'Connor, Cleveland
Aaron S. Raisin, Cleveland
John Y. Ranchoff, Cleveland
Earl K. Shirey, Cleveland
Clarence G. Smith, Cleveland
Richard B. Stoughton, Cleveland

FAIRFIELD COUNTY

Paul M. Whetstone, Millersport

FRANKLIN COUNTY

William W. Davis, Columbus
Willard B. Fernald, Columbus
Lewis T. Franklin, Columbus
Ruth C. Haynes, Columbus
Lester E. Imboden, Columbus

GREENE COUNTY

Gregory B. Krivchenia, Fairborn

HAMILTON COUNTY

Paula Biren, Cincinnati
Edwin E. Gallenstein, Cincinnati
George E. Kachele, Cincinnati
Joseph V. Morris, Cincinnati
Gisela A. Munzinger, Cincinnati
Denman Shaw, Cincinnati
George D. Tchakmakoff, Cincinnati
William F. Walker, Cincinnati

HOCKING COUNTY

Jan S. Matthews, Logan

LAKE COUNTY

Floyd W. Dick, Jr., Madison
Marvin I. Kohn, Fairport

LICKING COUNTY

Elinor T. Christiansen, Granville
John A. Mitchell, Newark
Howard Peppel, Newark

LORAIN COUNTY

Mary Louise McElwee, Oberlin
Antoni Trzeciak, Avon Lake

LUCAS COUNTY

Ronald A. Gandy, Jr., Toledo
Saul R. Kelson, Toledo
James H. Miller, Toledo
Bernard Rapoport, Toledo
Harry L. Snyder, Toledo

MAHONING COUNTY

Ben C. Berg, Jr., Youngstown
Eisa Shapira, Youngstown
George X. Trimble, Youngstown

MONTGOMERY COUNTY

Warren Kaebnick, Dayton
David E. Waugh, Dayton

PORTAGE COUNTY

Milorad Andrial, Ravenna

SANDUSKY COUNTY

Paul E. Burson, Bellevue

SUMMIT COUNTY

Edward Davison, Akron
George E. Lerner, Akron
Robert R. Roberts, Akron

VAN WERT COUNTY

Harold C. Smith, Van Wert

WAYNE COUNTY

Albert A. Wasserstein, Apple Creek

A new 16 mm. color motion picture on uses of steroids in treatment of rheumatoid arthritis is available for showing to professional groups from the Audio-Visual Department, Schering Corporation, Bloomfield, N. J. It is the fourth in a series on hormone therapy and the endocrines.

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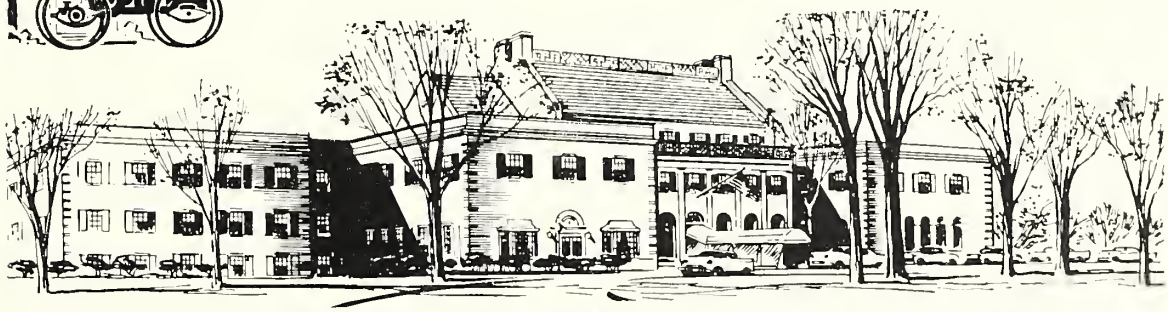
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Rule on Attendance at Staff Meetings Is Altered by JCAH

The Joint Commission on Accreditation of Hospitals has modified the Standard pertaining to attendance at medical staff meetings.

The new Standard reads: "Active Staff attendance shall average at each meeting at least 50 per cent of the active staff who are not excused by the Executive Committee for just cause. Each active staff member shall attend 50 per cent of staff meetings unless excused by the Executive Committee for just cause."

The old Standard was: "Active staff attendance shall average at each meeting at least 75 per cent of the active staff who are not excused by the Executive Committee for just cause. Each active staff member shall attend 75 per cent of staff meetings unless excused by the Executive Committee for just cause."

The modification of this Standard was recommended by the Committee on Standards which was charged by the Board of Commissioners to consider the "Conclusion of the Stover Report."

The Stover Report of the AMA stated that staff meetings required by the Commission are acceptable but the attendance requirement should be set up locally and not by the Commission.

The Board of Commissioners voted to accept the recommendation of the Committee on Standards for the following reasons:

1. A well functioning medical staff with good intercommunication is essential to insure quality medical care.

2. The general staff meeting is an important tool both as an administrative and educational device to keep the staff as a whole informed of hospital activities and to insure continuity of good medical practice.

3. It is essential that every hospital have rules and regulations pertaining to attendance at medical staff meetings. In order to make certain that these rules are adequate, the Commission should furnish a specific yardstick in the Standards.

COMING MEETINGS

1957 Annual Meeting, Ohio State Medical Association, Columbus, May 14, 15 and 16.

American Medical Association, Annual Session, New York City, June 3-7.

American College of Chest Physicians, New York City, May 29 - June 2.

American Neurological Association, Atlantic City, N. J., June 17-19.

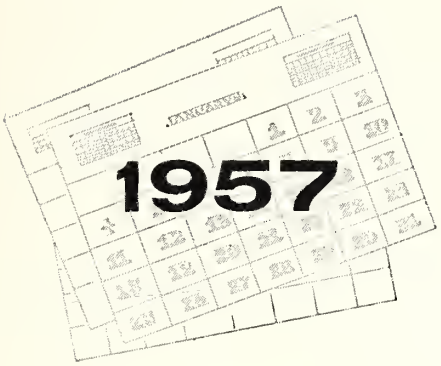
Ohio State Medical Golfers' Association, Annual Tournament, Columbus, June 21.

Ohio State Radiological Society, Annual Meeting, Dayton, May 24-26.

Veterans Administration Clinical Conferences, Cleveland, weekly on Wednesdays.

INDEX TO ADVERTISERS

Abbott Laboratories ..... 512 - 513
American Meat Institute 517
Ames Company, Inc. 608
Appalachian Hall 532
Ayerst Laboratories, Inc. 583
Barry Laboratories, Inc. 534
Bayer Company, The, Div. of Sterling Drug Co., Inc. 619
Burroughs, Wellcome & Co., (U.S.A.) Inc. 612, 618
California State Personnel Board 607
Ciba Pharmaceutical Products, Inc. 615
Columbus Pharmacal Company 614
Cook County Graduate School of Medicine 600
Corn Products Sales Co. (Karo) 514
Davies, Rose & Co., Ltd. 598
Dearborn Inn, The 605
Ethicon, Inc. 533
Flint, Eaton & Company 519
Foot-so-Port Shoe Company 600
Gallagher-Roach & Company 591
Geigy Pharmaceuticals, Inc. 613
Harding Sanitarium 524
Hoffmann-LaRoche, Inc. ..... Insert between pages 604-605
Knox, Chas. B., Gelatine Co., Inc. 511
Lakeside Laboratories, Inc. 505
Lederle Laboratories ..... 531, 566-567, 596 - 597
Len-A-Pe Village 599
Lewal Pharmaceutical Company 516
Lilly, Eli, and Company 536
Lloyd Brothers, Inc. ..... 610 - 611
Loma Linda Food Company 616
Mallard, Inc. 603
Manitowaning Lodge 589
McMillen Sanitarium 524
Medical Protective Company 604
Merck Sharp & Dohme ..... 528 - 529
Neil Training School 585
New York Polyclinic Medical School 589
North, Emerson A., Hospital, The 510
Parke, Davis & Company ..... 620 and inside back cover
Pfizer, Chas. & Co., Inc. 509, 515, 593, 601, 609
Picker X-Ray Corporation 522
Pogue, Mary, School, Inc. 602
Quincy X-Ray & Radium Lab. 599
Riker Laboratories, Inc. 525
Robins, A. H., Co., Inc. 523
Roerig, J. B., & Co. 507
Sawyer Sanatorium 527
Schering Corporation 535
Scroggins, Clayton L., Associates (Medical-Dental Management) 614
Searle, G. D., & Company 587
Smith, Kline & French Laboratories ..... 526 and back cover
Squibb, E. R., & Sons, Division of Olin-Mathieson Chemical Corporation 617
Stoneman Press 530
Tutag, S. J., & Company 530
U. S. Vitamin Corporation ..... 594 - 595
Wallace Laboratories ..... Insert between pages 520 - 521
Wendt-Bristol Company 604
Windsor Hospital, Inc. 602
Winthrop Laboratories 532, 605
Year Book Publishers, The, Inc. 521



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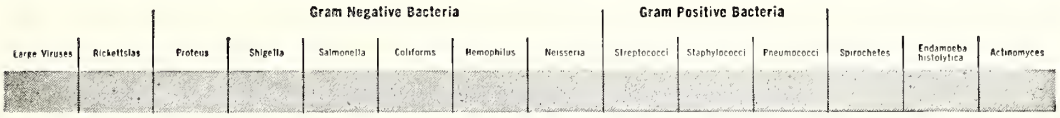
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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

Diseases of the Skin, by Richard L. Sutton. ($29.50. 11th edition. *C. V. Mosby Co., St. Louis 3, Missouri)*, with its 1972 illustrations makes a worthwhile atlas. The text has been brought up to the date of closing the galley proof. Another helpful feature is the inclusion of a dictionary and an encyclopedia as a guide to the maze of what may be found. The current character of the text in a book of this magnitude (1480 pages) is most remarkable.

Great Men: Psychoanalytic Studies, by Edward Hitschmann, M. D. ($4.00. *International Universities Press, New York 11, N. Y.)* The biographies of Freud, Schopenhauer, Goethe, Johann Peter Eckermann, Samuel Johnson, Boswell, Johannes Brahms, Swedenborg, William James, Franz Werfel, Albert Schweitzer, Gottfried Keller, Auguste Comte, Selma Lagerlof, Knut Hansum, Max Dauthendey, Mahatma Gandhi, are analyzed by the author. It is an outstanding example of applied psychoanalysis.

Dictionary of Dietetics, by Rhoda Ellis. ($6.00. *Philosophical Library, New York, N. Y.)* This is a compilation of terms and references related to diet and diet therapy. It is of interest to both lay and professional people who are concerned about diets, nutrition and foods as well as dietetics.

Becoming a Mother, by Theodore R. Seidman and Marvin Albert. ($3.50. *David McKay Company, Inc., 55 Fifth Ave., New York 3, N. Y.)* This tells what every woman ought to know about fertility, conception, pregnancy and childbirth.

Therapeutic Education, by George Devereux. ($5.00. *Harper Bros., New York, N. Y.)* This volume is the first book-length discussion of the general theory and practice of education for all types of mentally or emotionally disturbed or defective children. The emphasis here is on Education.

Children and Other People—Achieving Maturity Through Learning, by Robert S. Stewart and A. D. Workman. ($2.25. *The Dryden Press, New York, N. Y.)* The book contains a great deal of information about the contemporary theory of personality development and the nature of emotional responses.

Psychotherapy and Counseling, edited by Roy Waldo Miner. ($3.50. *Academy of Seiences, 2 E. 63rd St., New York, N. Y.)* In the medical profession, psychotherapy is the primary responsibility of the psychiatrist. Nevertheless the physician, while functioning within the sphere of his professional competence and realizing how he can help the patient with his emotional problems, can have an impact on the emotional life of the patient that is profound and enduring.

The Rochester Regional Hospital Council, by Leonard S. Rosenfeld and Henry B. Makover. ($3.50. The Commonwealth Fund by the *Harvard University Press, Cambridge, Mass.)* This is a report of one of the most significant experiments in developing hospital service on a regional basis. The description includes the detailed account of the organization and activities of the Council of the 11-County area. It will interest all who are concerned with the maintenance and improvement of hospital services.

Psychology Applied to Nursing, by L. A. Averill, Ph. D., and F. C. Kempf. ($4.25. Fifth edition. *W. B. Saunders Co., Philadelphia, Pa.)* This is a popular text which now emphasizes the demands of the aging as well as the newer things in the care of the sick.

Your Marriage, by Norman E. Himes and Donald L. Taylor. ($5.50. Revised and enlarged. *Rinehart & Co., 232 Madison Ave., New York, New York.)* This is a book that covers those psychological, economic, and social facts of marriage so often disregarded in other books of marriage counsel.

Handbook of Physical Therapy, by Robert Shestack. ($4.25. *Springer Publishing Co., New York, New York.)* Physiotherapy has gained new recognition and wide use during the past decade. This book is based on observations made by the author during 14 years during which he administered nearly 100,000 treatments.

Gourmet Cookery for a Low-Fat Diet, by Elise Cavanna and James Welton. ($3.95. *Prentice-Hall Inc., Englewood Cliffs, N. J.)* This book is an ingenious new concept. It cleverly makes dishes thoroughly delectable on a minimum fat basis, showing you how to avoid not only butter but all oils, fats and greases.

The Complete Book of Low Calorie Cooking, by Leonard Louis Levinson. ($4.95. *Hawthorn Books, Inc., New York, N. Y.)* This book is packed with more than 600 low-calorie recipes medically approved. It is encyclopedic in scope, indispensable to the reducer, invaluable to the housewife concerned with the health of her family, and vital for the diabetic.

New and Nonofficial Remedies: 1926, Evaluated by the AMA Council on Pharmacy and Chemistry. ($3.35. *J. B. Lippincott Co., Philadelphia, Pa.)* This annual publication has come to have a place of importance in American Medicine. Descriptions are limited to those individual drugs gen-

erally available in the United States that have not been included in the U. S. P., N. F., or N. N. R. for a prior cumulative period of 20 years.

A Paris Surgeon's Story, by Charles F. Bove, K. L. H. ($4.50. *Little Brown and Co., Boston, Massachusetts.)* The autobiography of a distinguished surgeon from the staff of the American Hospital in Paris who served there for 25 years.

Principles of Renal Physiology, by Homer W. Smith. ($5.00. *Oxford Book Co., 222 Fourth Ave., New York, N. Y.)* An up-to-date presentation of the physiology of the kidney by the Professor of Physiology, New York University College of Medicine.

Practical Endocrinology, by Lewis M. Hurxthal, M. D. ($7.00. *Landsberger Medical Books Division, McGraw-Hill Book Co., New York 36, N. Y.)* This is a book written particularly for the busy physician, as are all the books in this series of "Handbooks for Busy Physicians." This is the first of the projected series. As the various disorders of each gland are described, there are methods of diagnosis and treatment and special chapters presented, dealing with hirsutism, gynecomastia, sterility, the steroid compounds, and simple laboratory procedures.

The Give and Take in Hospitals: A Study of Human Organization, by Temple Burling, M. D., Edith M. Lentz, Ph. D., and Robert N. Wilson, Ph. D. ($4.75. *G. P. Putnam's Sons, New York 16, New York.)* This book is a report of a study initiated by the American Hospital Association and conducted by the personnel of the New York State School of Industrial and Labor Relations of Cornell University. It is a highly readable report of the interaction between administration and staff and the results of this interaction in terms of patient care.

Peripheral Vascular Disease, by A. J. Barnett, M. D., and J. E. R. Fraser, M. D. ($9.50. *Melbourne University Press*, U. S. Distributor, *Cambridge University Press, New York 22, N. Y.)* This is in substance the monograph awarded the Stawell Memorial Prize of the British Medical Association. A fresh consideration of this disease is called for by its prevalence, by the new work that is being done to clarify its cause, by the necessity to assess the value of the many suggested remedies, and by the importance of proper diagnosis.

Doctor Kate: Angel on Snowshoes, by Adele Comandini. ($3.75. *Rinehart & Co., New York 16, New York.)* This is the biography of Kate Pelham Newcomb, M. D., known to millions of Americans because of her appearance on "This Is Your Life." It is the story of a woman doctor whose faith and devotion to her community saved hundreds of lives, built a church and hospital, and won the respect and love of all who knew her.

Mental Hygiene in Public Health, by Paul V. Lemkau, M. D. ($8.50. Second edition. *Blakiston Division, McGraw-Hill Book Co., Inc., New York 36, N. Y.)* After six years the author presents a wealth of new material and information which is indicative of the rapid growth in this field during those years. There is a host of new programing information, newly evolved general principles of programing, and extended case illustrations which include these new developments.

White Coolies, by Betty Jeffrey. ($3.75. *Philosophical Library Inc., New York 16, N. Y.)* Here is the first published account of the experiences of an Austrialian Army Nursing Sister in the hands of the Japanese. The story begins with the evacuation of the nurses from Singapore, and the sinking of the ship upon which they were traveling, their imprisonment and miserable life in prison camp. It is a grim story, but its darkness is lightened by the saving humor which the prisoner somehow managed to preserve.

We Can't All Be Sane, by William H. Kupper, M. D. ($1.75, paper; $3.50, cloth. *Colt Press, Patterson 3, New Jersey.)* The author, drawing on nearly 20 years' experience in analytical work with the mentally ill, tells of his experiences from state hospitals in the United States to combat zones in World War II.

Buccaneer Surgeon, by C. V. Terry. ($0.35, Pocket Book Series—reprint. *Pocket Books, 630 Fifth Ave., New York, N. Y.)* The hero was a surgeon to Sir Francis Drake, became a prisoner of the Spanish Inquisition, and led a most exciting life. From the quiet cloisters of Oxford to the decks of a pirate brig, from the boudoirs of Spain to the jungle, from the cells of the Inquisition to the sack of Cartagena, the hero fought and healed and conquered. He was a lusty rogue, a hot-blooded adventurer, a questing lover and a skillful surgeon.

From Custodial to Therapeutic Patient Care in Mental Hospitals, by Milton Greenblatt, M. D., Richard H. York, Ph. D., and Esther Lucille Brown, Ph. D., in collaboration with Robert W. Hyde, M. D. ($5.00. *Russell Sage Foundation, New York 22, N. Y.)* This book describes the principles and practices of patient care evolved by one of the advanced teaching and research institutions—the Boston Psychopathic Hospital, and reports of experiments in improved patient care undertaken in two much larger institutions—the Metropolitan State Hospital and Bedford V. A. Hospital, both in the Boston area.

Functional Otology, the Practice of Audiology, by Morris F. Heller, M. D. ($5.00. *Springer Publishing Co., New York, N. Y.)* This book presents every aspect of audiology in a concise and immediately applicable manner. Dr. Heller, along with B. M. Anderman and Ellis Singer, gives us co-ordinated information on this subject.

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The first subtle suggestions of physiologic deterioration should not be dismissed if serious somatic and metabolic disorders are to be avoided. Prompt institution of steroid-nutritional therapy may forestall and even reverse premature "damage" and help prolong the active life of the patient.

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Recommended dosages: Male—1 tablet or 1 capsule (or 3 teaspoonfuls) daily, or as required. Female—1 tablet or 1 capsule (or 3 teaspoonfuls) daily, or as required, taken in 21 day courses with a rest period of one week between courses.

Bibliography on request.

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Folic acid U.S.P.	0.33 mg.
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Comparison of Treponema Pallidum Immobilization and Treponema Pallidum Complement Fixation Tests

L. F. EY; CAL C. KERSELL, B. A., and ARTHUR H. BAUER, B. S.

THIS report is presented to review briefly some of the difficulties encountered with the standard serologic tests for syphilis and to show comparisons of Treponema Pallidum Immobilization and Treponema Pallidum complement fixation tests. The standard serologic tests for syphilis are those (Venereal Disease Research Laboratory [VDRL], Kline, Kolmer complement fixation, Kahn, Mazzini and Rein-Bossak) designed to detect reagin in patient's serum or spinal fluid. The reagin is an antibodylike substance which is present in syphilis infection and it is determined with the use of nonspecific antigen derived from an extract of beef heart combined with lecithin and fortified with cholesterol.

The Authors

- Mr. Ey, Columbus, is chief of laboratories;
- Mr. Kersell, Columbus, chief serologist;
- Mr. Bauer, Columbus, serologist,

—all with the Ohio Department of Health, Division of Laboratories.

EVOLVEMENT OF TREPONEMA PALLIDUM TESTS

In the Treponema Pallidum Immobilization test the antibody in patient's serum immobilizes the viable treponema in the presence of complement. The Treponema Pallidum complement fixation test is performed with an extract of Treponema Pallidum as an antigen. This extract detects the treponema antibody which is distinct from that of the antibody found by the Treponema Pallidum Immobilization test or reagin in the standard tests for syphilis.

The treponema tests have been developed in recent years by serologists in an endeavor to obtain a substance that reacts with maximum specificity and sensitivity with syphilitic antibody. To further elucidate, in the past the serologist attempted to achieve more specific findings in the diagnosis of syphilis by increasing the purity of the reacting substance, rather than utilizing the actual treponema with its complex chemical composition. For example, lipoidal antigen was the supporting agent in both the complement fixation and flocculation tests until cardiolipin antigen was recognized to show higher specificity and sensitivity. The fact that author-serologists, with one or two exceptions, found it expedient to use cardiolipin-lecithin antigen in place of lipoidal is self-explanatory.

The difficulty to resolve is how to separate patients who have treponema antibodies in their blood from those who have reagin of nontreponemal origin. In other words, we want a test to assist in differentiating between biologic false positive reactors and those indicative of syphilitic infection. Kahn[1] developed a method known as the verification test which was intended to detect false serologic reactions, but after many years of trial, it was replaced by methods

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using the spirochete of treponema pallidum as antigens.

CAUSES OF FALSE REACTIONS

In former years discussion as to probable causes of biologic false positives was centered around certain tropical diseases, alcoholics and patients receiving ether anesthesia. From our own experience as well as from other references, we know that biologic false positives are found in a variety of clinical conditions other than syphilis. Some of those involved are as follows:

- Lupus erythematosus
- Infectious mononucleosis
- Tropical diseases
- Certain vaccinations
- Active tuberculosis
- Herpes zoster
- Pregnancy
- Pneumonia unclassified
- Infectious hepatitis
- Rheumatic fever
- Upper respiratory infections
- Other infectious diseases

EXPERIMENTAL STUDIES

The Treponema Pallidum Immobilization test came into prominence in 1949 following the studies of Nelson and Mayer.[2] In this postwar period about five laboratories in different sections of the country made this service available to state health departments and other laboratories, Several years ago these laboratories discontinued accepting specimens for the Treponema Pallidum Immobilization tests. This action was taken so that their studies might be evaluated. Consequently, for about two years it was difficult to obtain Treponema Pallidum Immobilization tests from any laboratory.

In the summer of 1954, The Ontario Department of Health Laboratory, Canada, kindly offered to perform Treponema Pallidum Immobilization tests on serum referred by the Ohio Department of Health Laboratory and this uninterrupted cooperation remains in effect. About six months after this arrangement was made, the Venereal Disease Research Laboratory, U. S. Public Health Service again resumed Treponema Pallidum Immobilization service for state health department laboratories. The latter two laboratories will be referred to as our consultant Treponema Pallidum Immobilization laboratories in later parts of this report.

To show the significance of the Treponema Pallidum Immobilization findings versus those of serologic tests for syphilis in different stages of treated and untreated syphilis we quote from the Ontario Laboratory Report:[3]

> "that TPI antibodies are distinct from reagin and tend to persist relatively unaffected by treatment;—less sensitive than STS in primary and early secondary infection;—equally sensitive as STS in untreated secondary and tertiary infection; more sensitive than STS in cardiovascular, neurosyphilis, congenital and latent syphilis;—of greatest value as a verification test of so-called 'biologic false positive' reactions of STS."

More recently a complement fixation test utilizing treponema antigen, Treponema Pallidum complement fixation, has been reported by Portnoy and Magnuson[4] and from comparative studies made by these authors we quote as follows:

> "It is apparent that, in primary and secondary syphilis, the TPCF test is somewhat more reactive than the TPI test. In central nervous system syphilis, including tabes dorsalis, the TPI test was more reactive. In congenital syphilis, a slight advantage went to the TPCF test. In latent and cardiovascular syphilis, the two treponemal tests appeared to be about equally sensitive. In the 395 patients tested, the TPI and TPCF tests agreed in 87.3 per cent. Most of the disagreement results from the somewhat greater sensitivity of the TPCF test in early syphilis."

In the Ohio Department of Health Laboratory the Treponema Pallidum complement fixation test[5] was taken up experimentally in February 1956 after the antigen was available from commercial source. Originally we decided upon a series of sera from 100 suspected biologic false positive cases. Contamination or unsatisfactory sera decreased this number to 92 which were subjected to the tests. All specimens were accepted in accordance with the recommended specifications of the consultant laboratories, and the blood was collected and prepared by approved methods.[6] The patients resided in all sections of the state and the blood specimens were delivered through the mail service. Sera were divided into three aliquots, part being retained in this laboratory for the Treponema Pallidum complement fixation test and parts were forwarded by mail to the two consultant laboratories for Treponema Pallidum Immobilization tests.

COMMENTS

It will be noted in 69 cases (table 1), complete agreement was found in two Treponema Pallidum Immobilization and Treponema Pallidum complement fixation tests.

Among the 23 disagreements the results were as follows: In the 18 cases (table 2) positive agreement was found in one of the Treponema Pallidum Immobilization tests and the Treponema Pallidum complement fixation, or a total positive agreement of 59 in two tests.

In the remaining five sera, three were positive Treponema Pallidum complement fixation with negative Treponema Pallidum Immobiliza-

TABLE 1.—COMPARISON OF TREPONEMA PALLIDUM IMMOBILIZATION TESTS WITH RESULTS OF TREPONEMA PALLIDUM COMPLEMENT FIXATION

Names of Tests	Number of Cases	Positive Agreement	Negative Agreement	Complete Agreement (Pos. & Neg.)	Complete Disagreement
TPI & TPCF	92	41	28	69—(75%)	23—(25%)

TABLE 2.—DISAGREEMENTS IN TREPONEMA PALLIDUM IMMOBILIZATION TESTS

No. of Cases	Laboratory A		Laboratory B	
	Positive	Negative	Positive	Negative
18—(20%)	3	15	15	3

tion in both laboratories. Two were negative Treponema Pallidum complement fixation with Treponema Pallidum Immobilization positive in two laboratories.

In final analysis 87 cases, or 95 per cent, showed complete agreement with one of the Treponema Pallidum Immobilization and Treponema Pallidum complement fixation tests.

It is of further interest to comment that in our most recent experience with the Treponema Pallidum complement fixation test our laboratory and the Venereal Disease Research Laboratory found complete agreement in 26 specimens. This indicates high reproducibility of the Treponema Pallidum complement fixation test.

NECESSARY PROCEDURE TO FOLLOW FOR TREPONEMA PALLIDUM SERVICES

Assuming that Treponema Pallidum complement fixation and Treponema Pallidum Immobilization tests will continue to be available, the Ohio Department of Health Laboratory offers these services to physicians for trial in certain controlled cases. If the following criteria or prerequisites are fulfilled, specimens will be accepted for these examinations:

1. The patient's blood record should show two or more positive standard serologic tests.
2. There should be no clinical signs or symptoms of syphilis. (Spinal fluid tests should be made to exclude syphilis.)
3. "Patients with suggestive evidence of syphilis infection who have not received treatment.

"If the patient has received any injected antibiotics within one (1) month, or oral antibiotics within one (1) week, of the drawing of the blood specimen, an invalid or inconclusive finding in the TPI test may result."—(VDRL clinical data form.)

4. Specimens of blood from old treated cases of syphilis are not desirable.

Collection of Blood Specimens:

Blood should be taken aseptically and mailed in special containers furnished by the Ohio Department of Health, Central or Branch Laboratories.

Two sterile tubes with paraffin-coated corks and clinical data sheets are in each container. Collect 7 ml. of blood in each tube and return data sheets in same outfit.

SUMMARY AND CONCLUSIONS

Treponema Pallidum Immobilization procedures are complicated, time-consuming and expensive.

In our experience the Treponema Pallidum complement fixation test was found to be readily adaptable to our routine Kolmer complement fixation test.

Preliminary studies indicate the Treponema Pallidum complement fixation is highly reproducible.

The Treponema Pallidum complement fixation test has potentiality of replacing other treponema pallidum tests.

In order to determine the diagnostic value of the Treponema Pallidum complement fixation test, it should be utilized by physicians in suspected biologic false positive cases.

It is significant to note that 64 per cent of the 92 cases, reacted positively in two tests, the Treponema Pallidum Immobilization and Treponema Pallidum complement fixation, or in agreement with the original positive standard serologic tests for syphilis.

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Action and Clinical Use Of Barbiturates

BARBITURATES: This is still a very important group of drugs as three hundred tons of barbiturates are used per year in the United States. An average of 15 per cent of all suicides are the result of barbiturate poisoning. During the years, 2500 different compounds have been synthesized and about 50 marketed for clinical use.

The action is one of a depressant on the cerebral spinal system. Normal sleep usually is produced. Even the electroencephalogram tends to assume a normal sleep pattern. Habituation is not frequent. Addiction does occur and is more serious than morphine. Barbiturates disperse to all tissues of the body and even pass the placental barrier into the tissues of the fetus.

Destruction in the body or elimination by the body depends on the type of barbiturate used. For instance, barbital and phenobarbital are excreted mainly by the kidneys, whereas pentabarbital and secobarbital are debraded by the liver.

The barbiturates remain the largest group of drugs prescribed as a sedative during the day time and as a hypnotic at night.—L. Maxwell Lockie, M. D., Buffalo, N. Y.: *Arizona Medicine*, 14:143, March, 1957.

The Alcoholic in Group Psychotherapy With Psychotic Patients

BURMAN H. PRESTON, M. D.

THE following observations were made during a period of five years' experience with some of the patients committed to Longview State Hospital because of the excessive use of alcohol. They have been seen in combined group and individual interview psychotherapy. The groups have ranged in size from eight to 24 patients with various diagnoses and not more than one or two alcoholic patients without psychosis in each group.

RELIEF FROM TENSION

The alcoholic patients who reject the first step in the Alcoholics Anonymous program resent being told they are helpless. They listen with suspicion to the inspirational messages of the alcoholics who have been successful. At panel meetings they ask questions that only God can answer. They are unable to recognize that they cannot stop using alcohol to excess. One by one they will say "I can take it or leave it." However, their life situation shows that they cannot take it or leave it. They are much more interested in getting relief from tension felt at the moment than in future success. Alcohol seems useful to them in getting rapid yet transitory relief from tension.

SOCIAL DRINKERS

The social drinkers are those who use alcohol for the relief of some of the tensions met with in daily life. In one sense of the word such individuals are alcoholics in that they use alcohol to relieve tension and gain increased pleasure in living. When the problem is too deep, the tension can only be relieved with severely toxic amounts of alcohol. Then the use of alcohol itself becomes an additional problem.

The longer they use alcohol, the more is required to get the desired relief from tension. This leads to organic brain damage with defects in judgment and clouding of sensorium. It will require at least one year away from the toxic effects of alcohol for such patients to get maximum improvement of those neurones that have not been damaged beyond repair. Most improvement will be noted during the first six months of hospitalization.

In addition to organic brain damage, these patients may present so-called functional mental disorders. While the alcoholic patients will vary in the amount of organic brain damage, organization of personality structure and type of functional mental illness, they have two things in common: (1) an unresolved conflict in the personality; (2) they have used alcohol in an effort to solve the problem. The prognosis in any individual patient will depend upon the nature of the disturbance in the personality structure, and by the length of time and quantity of alcohol that has been used.

Presented before the Ohio Psychiatric Association April 11, 1956, at the Annual Meeting of the Ohio State Medical Association.

The Author

● **Dr. Preston, Cincinnati, is a member of the medical staff (psychiatry) at Longview State Hospital.**

PERSONALITY PATTERNS

The convivial trends released by alcohol will conceal basic schizophrenic withdrawal patterns and at the same time bizarre ideas will be attributed to the use of alcohol by casual observers. In some, schizophrenic trends will be released early in such an obvious manner that friends will notice the presence of serious mental disorder early in the course of the use of alcohol.

Under the influence of alcohol, the cyclothymic personalities will show depression and exaggerated dependent needs (the crying drunk) or will become hypomanic. They may alternate between the two. The mania seems to be denial in an effort to escape from feelings of depression.

The passive, aggressive personality type is met with most often in alcoholic patients. Those who are using the aggressive variation of this pattern seem to be making use of the mechanism of denial to escape from the recognition of the excessive demands of their passive dependent trends.

PROGNOSIS FOR IMPROVEMENT

The alcoholic patients who present evidence of brain damage and who do not recover after a year away from alcohol, will continue to present the picture of an organic psychosis. They will present a rigid personality structure with a repetition of the pattern of using alcohol to excess at every opportunity. Custodial care preventing the use of alcohol will be necessary. Humane custodial care and occupational therapy under supervision will help such patients to approximate their maximum capacity for achievement. Psychotherapy will not change this rigid pattern

of behavior. Only those who have recovered sufficiently from brain damage to be well oriented and capable of abstract thinking will be able to profit from psychotherapy.

Those alcoholic patients who eagerly accept the first step in the A. A. program do not have feelings of shame in regard to their passive dependent needs. Their need to cling to someone is met with a permissive attitude. This opportunity is siezed in a wholehearted manner. Yet these patients are most easily discouraged by any failure of those in the program. Such failure is interpreted by them as rejection. They feel "let down" and return to the usual pattern of using alcohol to relieve tension. In this way they express hostility toward those whom they believe have let them down. The use of alcohol becomes a defiant gesture and at the same time aids them to achieve a helpless dependent state that deep intoxication can produce.

"AM I AN ALCOHOLIC?"

In individual interviews a patient will almost always ask, "Am I an Alcoholic?" Such patients will usually accept this reply: "You are an alcoholic in the same sense that everyone who uses alcohol is an alcoholic. The social drinker uses alcohol to relieve tension in regard to a problem that is superficial. You are likewise using alcohol to relieve tension and achieve greater satisfaction in living. You have found it helpful or you would not have continued to use it. You differ from the social drinker in that your problem is more difficult to solve. If we can find your problem and you can learn a different way to solve it, the reason for taking a drink that has been present in the past will not exist. If you should take a drink in the future it will have a different meaning for you. You have been told that alcohol is your problem. Alcohol is not your problem. It is your way of trying to solve a problem."

The alcoholic patients without psychosis assume a superior attitude towards psychotic patients. Psychotic patients show deference in group psychotherapy to alcoholic patients without psychosis. For this reason they make good group leaders in alternate meetings when the therapist is not present. In individual interviews the interpretation is given that the patient without psychosis and those diagnosed as psychotic are similar in that the behavior of each has caused them to be committed to a mental hospital.

A DEFINITION

The alcoholic patients are those whose needs for oral gratification have not been satiated in infancy or they have found so much satisfaction in this level of emotional maturation they do not wish to give it up. Women will accept this attitude more readily than men. With men it is necessary to spend more time in discussing the universal nature of dependent needs. In therapy the alcoholic must gain the insight that his dependent needs are greater than the social drinker's needs.

The alcoholic patients who react with shame to oral dependent needs reject the first step in the A. A. program. They make use of the mechanisms of denial and repression. Often, the use of alcohol will be found to be an expression of hostility toward some significant person upon whom the patient wishes to be dependent. However the patients will explain the use of alcohol as an effort to show independence. The alcoholics seem to turn hostility upon themselves with excessive amounts of alcohol making themselves limber drunk and compelling the significant person or someone else to care for them in this helpless state.

HOMOSEXUAL TRENDS

Alcoholic men, when under the influence of alcohol, will show tender affection for fellow alcoholics of the same sex. This seems a genuine tender feeling that must be discussed and approved. Those alcoholics who show tender affect for members of the opposite sex seem to present a pseudo-hetrosexual flight to escape from tender affect for members of the same sex. These tender feelings must be discussed and accepted without shame and denial. They must recognize that overt homosexuality is not so much homosexual as it is infantile.

TREATMENT

My observations of those who have been treated for alcoholism before being committed to a state hospital lead to the conclusion that psychotherapy can be done more effectively in a state hospital than in private practice.

The psychic shock of being committed and being made a ward of the state causes the patient to mobilize all the positive factors in the personality. At first there may be a feeling of hopelessness and despair but this serves the basic need to be helpless and dependent. The patients who have not been committed may discontinue therapy when unpleasant interpretations are given. This is especially true when the patients are financially independent. They have feelings of security that great wealth can give. They seem to think they can satisfy passive dependent needs with money. In a state hospital the expense to significant relatives is minimal. This promotes a good therapeutic relationship between the patients and their families.

When a positive transference relationship begins to develop, patients cannot be removed from therapy by dominating relatives with a need to keep the patient on an infantile level. Such relatives will become frightened at this possible loss, but cannot remove patient from therapy. The therapist has better control over the signifi-

cant relatives as well as the patients. When a negative transference occurs, the patient can attend other groups and work through the relationship with another therapist without too great a time loss between therapists. Those unable to profit from psychotherapy can receive custodial care and achieve marginal independence in occupational therapy.

The therapist, in a state hospital, demands no pay from the patients. The dependent need of each alcoholic patient, at first in therapy, requires a feeling, "I am getting something for nothing." The only demand the therapist makes is a gradually increasing capacity to achieve a greater degree of independence. The complete loss of personal freedom produced by commitment is interperted as being helpful, in that it satisfies a psychological need to be helpless and dependent.

CUSTODIAL CARE

Many think of custodial care as incarceration and punishment. It saves the lives of many who would commit suicide gradually or perhaps suddenly by excessive drinking of alcohol. It satisfies a passive, dependent need. It makes for gradual movement from a helpless state to one of gradually increasing independence. If an alcoholic patient does not remain for at least a year in custodial care in a mental hospital before leaving on convalescent care, the hospital will become a place for the patient to sober up between alcoholic bouts.

CASE NO. 1

Mrs. X was an alcoholic patient without psychosis in a class of psychotic patients in group psychotherapy. She did not participate very much in the class discussions. However, she developed a positive transference in the group so that when she was seen in individual interview therapy, significant material was rapidly uncovered.

She presented a picture of agitation. She appeared to be under tension most of the time. She was unable to adjust in a marital situation. She was not able to participate in sexual intercourse with her husband without being under the influence of alcohol.

Primal scene trauma was uncovered in individual interviews. She could remember tearfully pleading with her mother's lovers during coitus, "Don't hurt my mommie." The fears associated with these primal scenes were discussed as being normal fears for that age. The interpretation was given, "You are permitting fears normal for the situation in which they occurred to influence your feelings in regard to coitus with your husband. Your need is to recognize that you are not that little girl and there is no necessity for you to let feelings suitable for your childhood experience to control your behavior now."

In the group, the question was asked, "In what way are you different now from the way you were when you were a little child?" Each member of the class was asked to discuss this question.

During this discussion, Mrs. X began to alternately laugh and cry. I ignored this behavior in class. After the class, in individual interview, I asked her what happened in class. She replied, "It occurred to me suddenly, I am not that little girl now."

This patient was able to leave the hospital within a short time, after this insight, and has been able to remain out for the past five years.

CASE NO. 2

Mrs. Y was another alcoholic patient in group psychotherapy with psychotic patients. In individual interview, she was fearful. In the group, the patient was able to feel safer and could produce more material and consider interpretations she could not tolerate in individual therapy. She was able to discuss how her feeling for her husband had changed in such a way that the same feelings now were disturbing and led to the use of alcohol.

She was also able to remember sitting on her father's lap with enjoyment. She remembered how she became ashamed of that feeling. She was able to recognize the similarity of the disturbing feelings about her husband and the feelings of shame she felt because of enjoying sitting on her father's lap. The interpretation, "You are acting as if your husband were your father" was accepted.

She has been able to leave the hospital and has been discharged. She has not returned to the use of alcohol.

CASE NO. 3

A male patient was able to recognize he had been imitating his father. He had identified with his father in such a way he felt he must imitate the father's undesirable traits—namely, periodic alcoholic bouts, as well as the worth-while tendencies.

He was able to see he had worshipped his father rather than honored him. This patient was able to see himself as an individual rather than considering himself, "a small chip off an old block." He was able to identify with some traits his father had, and reject others.

CONCLUSION

The alcoholic patient must recognize the universal nature of dependent needs. They must become aware of the factors that have made their oral, dependent needs greater than others. They must see that alcohol in rendering them helpless has been satisfying their basic need by producing a dependent state. They must see the infantile nature of their oral, dependent needs and reject them. They must learn more mature ways to satisfy passive, dependent needs.

This insight must be followed by the ego functions combining with the super ego to change repression to suppression. This must be followed by a wish to achieve a gradually increasing degree of independence. This must be met in a practical way by movement from the ward to other hospital activity to the community. In the alcoholic patient, the super ego alone is not able to provide adequate discipline and repression of early oral, dependent patterns of behavior. The participation of the integrative and executive factors must be available for suppression and sublimation of narcissistic patterns.

Coffee and Obesity

LEO B. JANIS, M.D.

OUR obese patients, as demonstrated in every doctor's office, need every bit of help they can receive. I think it is important to discuss one factor in weight management that, as yet, I have never seen in print. Statistics show that our results in maintaining weight are poor. The most common story heard in the office is the oft repeated tale of losing weight satisfactorily and in a period of six months regaining it. With the help of our present-day medications, and our present-day knowledge, loss of weight is not as difficult a problem as it once was. And yet, a routine for holding the weight that the patient has lost has not shown good results.

If the average obese patient seen in the office has such a difficult time in adhering to a sensible, scientifically prepared dietary routine, then any minor aid that can be discovered should be utilized. By this time I believe most physicians having any experience in the field of obesity will agree that one of the major factors that brings about defeat in the maintenance of weight, is our difficulty in effecting any control over the patient's everyday emotional routine.

To instruct patients in a basic diet to control their dietary intake, qualitatively and quantitatively, is no difficulty at all. In the office the patient cooperates beautifully. On subsequent visits a review of their dietary routine reveals few errors—and yet the weight continues upward. The average housewife, with her frustrations, anxieties, and emotional crises, must be made to realize that in her particular case, she is evidently turning toward food as an escape from her emotional disturbances. The psychotherapeutic approach, of necessity, must be varied with each individual case.

THE DISADVANTAGES OF COFFEE

As in any emotional problem, the time and expense involved limits its approach to the average obese patient seen in the office. Therefore, if one could eliminate, simply and easily, one factor that is pertinent to almost all cases, it would be a welcome step in our armamentarium directed toward weight control. We have such a factor. Caffeine. If nerves play such an important part, if emotional factors are usually blamed as the underlying cause, then why do we continue to allow our patients to stimulate themselves, thus causing a degree of flare-up in the very factors that we are attempting to control? Since early medical training we have been taught that caffeine is a powerful central nervous system stimulant. Let us review briefly the pharmacological action of caffeine.

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Caffeine is the tri-methyl derivative of xanthine, the principal alkaloid of coffee and tea. Caffeine in moderate dosages, in the form of its beverages, is a popular stimulant aiding mental and muscular effort, dimming drowsiness, and giving the sensation of comfort and cheerfulness. With larger doses these effects pass into wakefulness, nervousness, excitement, tremor, palpitations, headaches, vertigo, anxiety, and nausea. The pulse is full and hard, quickened or slowed, with palpitations and precordial distress. The head is heavy, throbbing, confused; often the individual suffers from intense headache and great anxiety, restlessness and excitement together with insomnia. Gastric distress, excess perspiration, tremors of the jaws, hands, and feet, quickened respiration and increased micturition are also seen.

Idiosyncrasy toward caffeine is marked. Children and nervous and weakened individuals appear to be more susceptible. A cup of coffee contains approximately 1.5 grains of caffeine and essentially the actions are those of the alkaloids. They consist in increased mental and physical efficiency, psychical stimulation, comfort and relief from muscular and mental fatigue. These effects may be useful in certain conditions, as in those exposed to severe hardship, hunger, fatigue, etc., but ordinarily they are mere luxuries. They may do no harm if the consumption is kept within bounds; but nervous individuals who are the most apt to be injured by caffeine, are most likely to exceed these bounds.

ADVANTAGES OF DE-CAFFEINATED COFFEE

In decaffeinated coffee the caffeine has been reduced to insignificant proportions.* Such coffees produce practically no effect on blood pressure, pulse rate, response to motor tests, or

*Caffeine content per cup prepared from the regular ground coffee bean is roughly three times that of the regular decaffeinated coffee and about four to eight times that of instant decaffeinated coffee.—Robert G. Martinek, Pharm. D., and Walter Wolman, Ph. D., J. A. M. A., 158:1030-1031, July 23, 1955.

oxygen consumption. The caffeine content per cup prepared from the regular grown coffee bean is roughly six to eight times that of the instant, decaffeinated coffee.

The imbibing of coffee and its subsequent effect upon the nervous system should be contraindicated in any integrated dietary routine.

It has been my experience that the majority of obese patients drink considerable quantities of coffee. The average patient consumes approximately six cups of coffee a day. Our high extremes vary tremendously. I vividly recall one housewife who consumed on the average 20 cups of cold, black coffee daily. If the average cup of coffee contains 1.5 grains of caffeine, this particular patient, and all others like her, daily stimulate their nervous system with 30 grains of caffeine. Seeing that one of our most potent injections for cardiac distress, respiratory distress and shock is 7.5 grains of caffeine sodium benzoate, this particular individual is taking the equivalent of four injections daily.

What doctor would prescribe four injections of 7.5 grains of caffeine sodium benzoate daily to his normal, healthy (but obese) office patient? And yet, under our very noses we are seeing individuals who consume at least that much, if not more, caffeine daily. Because we should attempt to do something about the emotional life of the patient, and because caffeine stirs up the emotional life of a patient, I think it should be called to the attention of the practicing physician that by rechanneling one apparently insignificant part of his patient's diet, a great degree of benefit would be attained.

The simple procedure of eliminating coffee and substituting decaffeinated coffee has been a practical approach to the problem. Once sufficient instruction as to the reason for the necessity of the change has been given, most patients readily switch their habit. The results have been extremely satisfying. The patients report a lessened inward tension which allows them to go through their everyday emotional pattern with more equanimity. The individual finds that she has a lot more patience with her children. There is less of a tendency to shout, scold, and use disciplinary actions, which on hindsight turn out to be normal behavior patterns. The individual discovers she is able to be less of a martinet about her household chores. She no longer is quite as upset about ashes on the carpet, tardiness at mealtime, or shoes on the stairway. In general, the consensus is that the individual's stress and strain, and pace of life are more tranquil.

LIQUID CONSUMPTION AND COFFEE

In addition to the decrease of nervous tension, one must take into consideration, as regards weight maintenance, the decrease in volume of liquid consumed. It is of interest to note that the same patient who consumed 20 cups of coffee per day, now does very well on four cups of decaffeinated coffee. The above mentioned patient, who was sufficiently impressed with the rationale for eliminating coffee from her diet, now finds that in a period of a month she roughly decreased her liquid intake by 15 gallons.

Anyone experienced in the field of obesity soon realizes that liquid intake plays a very significant role. As witness the gain in weight prior to and during the menstrual period, and also the marked fluctuation in weight during the hot summer months.

It is almost impossible to approach the patient from the standpoint of eliminating coffee from the diet, even though the patient quickly perceives the importance of this measure. The "kaffee klatch" has such a tremendous hold as a daily ritual that to disturb this rite requires more will power than the patient is often able to command. To expect the patient to join in the "klatch" with a glass of skim milk or grapefruit juice is ridiculous. It immediately sets them apart from the others. And the amount of discussion, insults, and jibes makes it too difficult for the patient to endure. However, the same individual can easily remain a part of the group by usage of a product that so closely approximates coffee—decaffeinated coffee. In practice, the substitute works out to a double advantage to the obese patient:

(1) No extra stimulation of their already highly stimulated nerves.

(2) A marked decrease in the amount of coffee consumed. For while it may be true that one cup of coffee leads to another, it is also true that one cup of decaffeinated coffee does not lead to another; accordingly, the volume of liquid is greatly reduced.

SUMMARY

(1) Pharmacologically, caffeine is a potent stimulant.

(2) It is generally agreed by both patient and physician that "nerves" play an important role in weight gain.

(3) Overdosage of coffee, with its 1.5 grains of caffeine per cup, stimulates nerves which causes an increased nervous tension. Increase in nervous tension leads to more "nerves" which causes more "nibbling."

(4) Unregulated liquid consumption by the obese patient brings on a gain in weight.

(5) By decreasing coffee down to not more than three cups daily, one can help an obese patient maintain his or her weight more easily.

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The Problem of Recurrent Postoperative Adhesions

WARD MEYERS, M. D.

THERE is no surgeon who has not at frequent intervals shaken his head and fervently wished for a method of successfully preventing intraperitoneal adhesions from forming following the intra-abdominal procedure of the moment. We are all fully aware that regardless of how fine the technique, how closely the rules of sterility are observed, how well the gloves have been washed free of powder, there are certain patients who will be adhesion formers notwithstanding.

In every group of surgical patients, there are always some, unfortunate be their lot, who tend to heap up peritoneal fibrous tissue under the best of circumstances, even with the simplest sort of surgical procedure performed inside the abdomen. Conversely, all surgeons have had the experience of opening the abdomen of patients seen previously with overwhelming peritonitis, and finding an abdomen relatively free of adhesions, even though the previous catastrophic pathology would invite the formation of a maze of adhesive strands.

ETIOLOGY

It would be well if an investigator could work out the reasons for the overwhelming adhesive inflammatory reaction in one peritoneum, and the lack of this reaction in another. If the true etiology were known, perhaps a more rational preventive could be instituted as a routine portion of surgical technique. The author suspects that the future will bring a wider understanding of the physiology of the body's fibrous tissue, and with it perhaps a better understanding, among other things, of the formation of adhesions. Perhaps the solution will lie in the direction of study of the relationship between the endocrine balance and the fluid transudate, or the cell types in the underlying inflammatory reaction of the peritoneal response. In any event, one must accept the fact that some unknown factor operates in the "adhesion former."

It is well to consider the presently understood physiological reasons for the adherence of peritoneum to peritoneum, with resultant formation of adhesions. Basically the process is an apparent attempt on the part of the body to protect the peritoneal envelope and its contents from contamination. The peritoneal lining is capable of localized or widespread inflammatory reaction against any contamination of its sealed cavity, be it from outside the abdominal wall or within the bowel. The inflammatory reaction takes place in and under the smooth membranous surface, is followed by a transudate of fluid and elements from the blood stream, and finally the insulting agent is successfully or unsuccessfully sealed off and localized away from the rest of the abdominal cavity.

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Unfortunately, the peritoneum involved in this localizing, sealing-off process is too frequently the serosa of the bowel. When this occurs, a catastrophe of much greater importance is possible, since the bowel can loop itself around an inflammatory adhesion which persists and obstruct itself. In certain cases, this process evidently occurs merely as a result of operative handling and examination. How often one sees in practice the individual with a history of past surgery, and with present complaints compatible with incomplete or variable obstruction on the basis of possible postoperative adhesions. How difficult the problem of trying to evaluate this type of situation. How easily mimicked is the syndrome by the neurotic!

It is for this reason that the author has attempted to bring together the present-day methods of not only attempting to prevent adhesion formation at the time of surgery, but also treating the resulting obstruction from adhesions, and reference will be made to the experience of himself and his associates with the Noble operation.

The Noble procedure of plication of small bowel in such a manner as to form adhesions in a pattern chosen by the operator has been variously called to the attention of the profession by articles appearing in the literature in the last two decades. Its usefulness cannot be overemphasized, since it will restore normal alimentation on a permanent basis in cases of recurrent small bowel obstruction due to adhesions.

"OMENTAL SYNDROME"

Before listing the various methods of adhesion-prevention at the disposal of the surgeon today, it would be well to mention the so-called "omental syndrome." This symptom complex is vari-

able, but may contain any or all of the following signs and symptoms:

1. Intermittent cramping pains in the abdomen, with or without localization.
2. Soreness persisting under an operative scar.
3. Variable constipation.
4. Nausea and vomiting, usually between meals.
5. Borborygmi.
6. A "doughy" consistency to the abdomen on palpation.
7. Sensation of "pulling" within the abdomen with changes in position.
8. The so-called "omental" sign: The patient stretches full length in a supine position, with arms extended above the head, and inhales deeply, followed by rapid exhalation. A painful pull on deep expiration is thought to indicate low abdominal wall adherence of the omentum to an operative scar or to pelvic organs.

It is obvious that the foregoing is not so much a syndrome as a symptom complex which may fit the diagnosis of intraperitoneal adhesions. Unfortunately the laboratory cannot help too much in further investigation of the situation, since chemistries are not usually deranged and blood counts are not abnormal. Roentgenograms are unreliable, since the small bowel does not lend itself to visualization so nicely as the proximal and distal ends of the gastrointestinal tract do. Occasionally an ordinary scout film of the abdomen with findings of dilated localized loops will serve as further deductive evidence of intermittent obstruction, but as often as not, no two successive films will look the same. Thus, the surgeon finds himself once more wishing that the problem of adhesions could be solved by prophylaxis, rather than by repeated lyses of adhesions, combined with prayer.

BASIC RULES OF PREVENTION

At the present moment, there are numerous points in technique and execution of procedure which can be utilized at the time of surgery to lessen the likelihood of adhesion formation. Among these are the basic rules of prevention:

1. **Strict observation of sterile technique.** This should not really bear repetition, since the art of surgery was founded on this basic principle. However, in these days of antibotics, one may have a tendency to disregard minor breaks in technique because of the feeling of security which antibotic availability has given.

2. **Washing away glove powder before intra-abdominal surgery.** Again, since the importance of glove powder peritonitis was realized long ago, and powders have been changed to minimize the peritoneal reaction, this point should not need emphasis. There still exists, nonetheless, a tendency to splash the powder away hurriedly and incompletely, especially about the gauntlets of the gloves. The rules have not changed; a thorough and studied rinsing of the gloves is still in order.

3. **Adherence to the rules of bacterial infection.** Where there is a localized purulent process, such as a ruptured appendix with abscess formation, a ruptured colonic diverticulum, a tubo-ovarian abscess, or a purulent cholecystitis, the surgery should be confined to a localized area involving only the purulent process. The abdomen should not be explored elsewhere, thus carrying bacteria to the other portions of the abdomen which the peritoneum has, up until now, protected. Again, this tendency has been noted since the advent of antibotic therapy with its feeling of false security.

4. **Bloodless technique and toilette.** The presence of blood and clots, left behind after definitive surgical procedure, is very irritating to the peritoneum, and the process of absorption is such that adhesions are almost a certain consequence. It may be that the early reports of success with the use of various solutions, such as urea, papaya juice, etc., depended on the lavage effect of the large amount of fluid used, rather than the direct effect of the chemicals themselves. A final "last look around" will usually yield a few small clots otherwise overlooked.

VARIATIONS IN PROCEDURE

In addition to the basic rules of surgical technique, attention must be called to further variations in procedure which are employed in the effort to prevent further adhesion formation.

1. **Avoidance of trauma in handling bowel.** If possible, rough sponging and pulling on serosa-covered viscera with sponges or packs is to be avoided. Gentle handling of the bowel with a suitable toothless forceps or a Babcock clamp will usually be as satisfactory as "pawing" with a sponge. It is only reasonable to suspect that rough handling of serosa with a woven-textured sponge will leave behind minute, or even microscopic tears, or roughening that will be sufficient to act as the nidus of a future localized adhesion.

2. **Exact utilization of the principle of "peritoneum to peritoneum."** Bowel surgery is founded on this principle, yet how frequently is a small tear in serosa of bowel or mesentery disregarded, or inaccurately closed, with a protruding bit of raw tissue to adhere to neighboring visceral peritoneum. An extra minute spent on this portion of an operation may save more operating room hours for the patient at a later date. Raw ends of ligated stumps of ovarian pedicles or appendiceal mesenteries, for example, can be buried with ease under nearby folds of peritoneum.

3. **Total removal of pre-existing adhesions.** The lysis of adhesions alone is not enough. Frequently the cut ends of sizable adhesions are left dangling from small bowel and parietal peritoneum: these should be cut out and an attempt

TABLE 1. UTILIZATION OF THE NOBLE PROCEDURE IN EIGHT CASES OF RECURRENT INTESTINAL OBSTRUCTION DUE TO ADHESIONS

Patient	Diagnosis	Previous Surgery	Type of Noble Procedure	Results
No. 1 Female	Acute small bowel obstruction. Perforation of ileum.	Bilateral salpingo-oophorectomy for bilateral tubo-ovarian abscess, 1-29-53.	Closure of ileal perforation. Lysis of adhesions. 80.8 cm. distal ileum formed in loops, 1-17-54.	Uneventful recovery; no further complaints.
No. 2 Female	Partial bowel obstruction. Ventral hernia.	Bowel obstruction, 11-21-45. Cholecystectomy & ventral hernia, 10-30-48. Lysis adhesions & hysterectomy, 2-28-49.	Lysis adhesions. 50 cm. distal ileum formed in loops, 6-15-53.	Uneventful recovery; no further complaints.
No. 3 Male	Completely frozen peritoneal cavity. Ileocutaneous fistula, etiology unknown.	Twelve previous attempts to lyse bowel obstructions over period of 5 yrs. Last attempt on 8-18-52.	Fistulectomy, lysis adhesions. Resection 2/3 of bowel and scar tissue en bloc. Remainder formed in loops, 9-12-52.	Recovered from procedure. Death from malnutrition in 6 months.
No. 4 Male	Multiple small bowel obstructions due to peritonitis.	Bilateral herniorrhapies, 2-4-53. Resection sigmoid colon, 12-6-53. Radical dissection aortic nodes, 12-15-53. Wound evisceration.	Complete Noble procedure, from Ligament of Treitz to ileo-cecal valve, 3-9-54.	Uneventful recovery; no further complaints.
No. 5 Male	Suppurative adenitis, ileal mesentery.	None.	One loop folded over necrotic glands, 2-22-53.	Uneventful recovery; no further complaints.
No. 6 Female	Small bowel obstruction.	Hysterectomy, lysis of adhesions, 11-5-43.	80 cm. terminal ileum folded in loops, 8-4-52.	Two months of cramping followed by complete relief.
No. 7 Female	Multiple ileal obstructions.	Bilateral salpingectomy, left oophorectomy, lysis of adhesions, 11-10-47. Oophorectomy, broad ligament cystectomy, hysterectomy, 7-27-48. Broad ligament cystectomy, 2-28-49. Volvulus, hernia, 8-2-49.	100 cm. ileum folded in 6 loops, 3-18-50.	2 months cramping, then complete relief.
No. 8 Female	Ileal obstruction.	Hysterectomy.	80 cm. in 4 loops, 3-7-51.	Uneventful recovery.

made to cover the ragged areas of origin. It is pleasing to see a clean peritoneal surface after this procedure has been carried out.

4. **Use of free omental grafts.** The omentum is a good source of free stamp or pattern grafts which can be utilized to cover raw areas when it is impossible to use the immediately contiguous normal peritoneum for serosa to serosa closure. This type of fatty peritoneal graft seems to be almost parasitic in its ability to take hold in a new location even when separated from the blood supply of the main body of the omentum. The author has used very sizable grafts in this manner, and transplanted them to parietal and visceral peritoneum without mishap.

5. **Use of free peritoneal grafts.** The edge of the admitting incision will furnish free stamp or strip grafts of peritoneum for use in a similar manner to the omental graft. These grafts are particularly suitable as replacement for lost bowel serosa, or as replacement for denuded liver capsule. When sutured in place with interrupted gastrointestinal catgut, a smooth gliding surface is obtained where before an obvious invitation to adhesion existed. If the grafts taken are not too large, no difficulty will be encountered in closing the peritoneum in the usual manner.

6. **Use of the "pexy procedure."** Occasionally, suturing an abnormally mobile organ, such as the cecum, to the abdominal wall will prevent recurrent adherence to a position lower in the abdomen. Again, the colon elsewhere, as in the case of a redundant sigmoid, may be kept up out of the pelvis by a well placed suture between its serosa and the lateral abdominal wall. In a sense, one forms new adhesions, except that in this case they are planned adhesions; these are formed in such a manner as to be compatible with life and comfort, rather haphazardly, with the possibility of bowel obstruction.

EMPLOYMENT OF THE NOBLE PROCEDURE

There is always the situation, however, in which the operator knows that none of the procedures mentioned in the foregoing will suffice to create a functional gastrointestinal tract and rule out the necessity for future exploration and lysis. He finds himself with large areas of denuded small bowel serosa extending over a distance of several feet, having lysed a number of points of incomplete small bowel obstruction. The problem then becomes one suitable for the Noble procedure, which in essence is a "laddering" of the small bowel upon itself in such a manner, that while adhesions form, they are created by the surgeon after a plan, and in such a manner that the bowel lumen is certain of remaining patent.

The turning curves of the bowel are laid out purposely and sutured into position in such a manner that the denuded areas cover each other with the bends in the bowel lumen gradual enough to insure a through track for the intestinal contents. The entire small bowel can be included in the procedure, so that when it is laid within

the abdomen, the ladder extends obliquely downward from left to right, following the direction of the mesentery, and presents a smooth surface to the anterior abdominal wall.

The procedure is adequately described elsewhere, and recently there has been a revival of interest in it. The author presents a few selected cases in the accompanying table 1, to point up the various situations in which the procedure can be utilized, together with follow-up results. As a general statement, it may be said that all of these cases have been successful in that the patients have not needed reoperation for obstruction, and most of them had histories of repeated operations for such previously. For a time, after the Noble procedure, there is usually some postoperative cramping, but when the patients understand the basis of the cramping, they usually cooperate fully and in a short time find themselves very comfortable and eventually are symptom-free. All are extremely grateful, especially those patients who have gone some length of time without recurrence of obstruction.

A glance at the type of case presented in table 1 will reveal that these were all difficult situations, calling for definitive protection against future complications, especially the complication of further bowel obstruction due to adhesions.

SUMMARY

The author has attempted to present a review of methods available for preventing the formation of intraperitoneal adhesions, together with comments on the experience of a surgical service in utilizing the Noble procedure. This report is presented in an effort to point up the necessity for adhering to careful surgical techniques and basic surgical techniques and basic surgical principles.

The Noble procedure is discussed briefly and its importance as a possible solution for the ever-present problem of recurrent intestinal obstruction due to adhesions.

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The Use of Antibiotics with the discovery of penicillin, and since then many new preparations have been developed in which the activity of the spectrum overlaps that of penicillin, such as tetracycline. The uses of these drugs have been spectacular in combatting infections. — L. M. Lockie, M. D.: *Arizona Med.*, 14:143, 1957.

KEEPING UP WITH MEDICINE

• IT SEEMS TRUE that there is a decline in the incidence and prevalence of rheumatic fever and rheumatic heart disease in children throughout the world.

* * *

• INJECTION of very small amounts of hypertonic saline directly into a hypothalmic area evokes an immediate and striking drinking response in experimental goats.

* * *

• GEOGRAPHIC TONGUE (denuded patches surrounded by thickened epithelium) may be due to allergy.

* * *

• INFECTIOUS mononucleosis in pregnancy or before conception may cause malformed infants.

* * *

• STUDIES of blood sugar changes in cirrhotics given glucose, glucagen, or epinephrine, show relative hyper- or hypo-glycemia compatible with diminished ability to lay down or release liver glycogen.

* * *

• IN RECENT YEARS, androgens alone or more commonly in combination with estrogens have been advocated in menopausal therapy more or less empirically. The advantages of combined therapy appear to be a synergistic effect on pituitary supression and the protein anabolic effect of androgen that presumably results in a sense of well-being and an increase in libido.

* * *

• THE ADVENT of insulin eliminated much of the clinical interest in fructose as an adjunct in the treatment of diabetes mellitus in man.

* * *

• PREMATURITY, infections, and diarrheas increase the susceptibility to scurvy.

* * *

• VERNAL CONJUNCTIVITIS is seasonal due to pollen or mold sensitivity, or perenial due to sensitivity to food bacteria, drugs, inhalants. Thirty-nine per cent of its victims are under 10 years of age.

* * *

• IT SEEMS clear that potassium as the chief intracellular cation is the result solely of its relative abundance in the earth's crust.

* * *

• NOT ONLY does carbohydrate play a major role in governing combustion and synthesis of fat in the framework of metabolism, but the relative quantities of carbohydrate given for energy influence inter-related protein and lipid metabolic processes essential to the normal catabolic pathways followed by fat.

* * *

• POSTMENOPAUSAL bleeding, namely, bleeding occurring more than one year following apparent cessation of menses, is a clear indication for curettage and delay in performing this is not justified.—J. F.

Bendectin® in the Treatment of Nausea of Pregnancy

RAY O. NULSEN, M. D.

BENDECTIN®* is a new medication which appears to be useful in the symptomatic treatment of nausea. Although primarily of interest in nausea and vomiting of pregnancy, it may also be helpful in radiation sickness, motion sickness, and other common causes of nausea. Each enteric coated tablet of bendectin® contains 10 mg. bentyl®* hydrochloride, 10 mg. decapryn®* succinate, and 10 mg. pyridoxine hydrochloride. Each of these compounds has been used alone in the treatment of various types of nausea.

The Author

● **Dr. Nulsen, Cincinnati, is a member of the active staff, Department of Obstetrics and Gynecology, Jewish Hospital, and attending staffs of Deaconess and Good Samaritan Hospitals.**

BENTYL®

Bentyl® hydrochloride has been used widely in the symptomatic treatment of functional bowel disease. Nausea and vomiting are two of the symptoms frequently mentioned among those usually responding to bentyl® medication.[1,2] Although it is an atropine-like substance, bentyl® has a peculiar specificity for the gastrointestinal tract.[3] This makes it possible to restore normal motility of the hyperactive stomach and intestine without producing blurred vision or a dry mouth.

DECAPRYN®

Decapryn® succinate is an antihistamine used primarily in the treatment of allergic disorders, but it has also been studied in the symptomatic control of nausea secondary to radiation sickness.[4] In a series of 168 patients, decapryn® alone proved highly effective in this type of case.

PYRIDOXINE

The somewhat controversial value of pyridoxine in the symptomatic treatment of nausea and vomiting of pregnancy has long been known. Recent support for the belief that there is actually a relative deficiency of vitamin B_6 in pregnancy, which is most pronounced in those patients suffering from nausea and vomiting, comes from the work of Wachstein and Gudaitis[5] who studied changes in xanthurenic acid excretion following administration of tryptophane. These studies indicated that the deficiency could be corrected by doses of 5 to 15 mg. pyridoxine daily.

Pyridoxine has also been reported as of value in nausea following anesthesia and radiation sickness.[6] These reports describe a total of 513 cases, most of which received symptomatic relief from pyridoxine.

BENDECTIN®

The present series consists of 203 adults and 2 children suffering from nausea associated with the menopause, motion sickness, pseudocyesis, and pregnancy seen in private practice. The distribution of patients and results are outlined in table 1.

TABLE 1. RESULTS OF BENDECTIN® THERAPY IN A SERIES OF 205 CONSECUTIVE CASES OF NAUSEA

Diagnosis	Number of Cases	Complete Relief	No Vomiting but Occasional Nausea	Failure
Menopause	1	0	1	0
Motion Sickness	3	3	0	0
Pseudocyesis	1	1	0	0
Pregnancy	200	175	24	1
Totals	**205**	**179**	**25**	**1**

In adults the single dose varied from one to three tablets and in most cases the drug was given once daily, at the hour of sleep. This was because most of the pregnant patients suffered from early morning distress and the enteric-coated tablet was best administered the night before. Those cases in which nausea occurred throughout the day were usually treated with one or two tablets twice daily. The two children in the motion sickness group each received half a tablet twice daily.

Duration of therapy varied from a few days up to 180 days. Complete symptomatic relief was obtained in 179 of the 205 patients and in another 25 there was no vomiting but occasionally nausea persisted. One patient received no benefit whatsoever. This patient subsequently required parenteral chlorpromazine.

In 88 of the 200 cases of nausea associated with pregnancy there was a history of nausea during a previous pregnancy. In 30 of these previous pregnancies treatment was with parenteral multivitamin preparations. In the remainder, the usual oral medications were employed. In 87 of these 88 cases, the patients reported more satisfactory relief from bendectin® than from the medication used during the previous pregnancy.

Only one side effect was reported. This was

Submitted June 28, 1956.

*Bendectin,® bentyl,® and decapryn® are all trade-marks of The Wm. S. Merrell Co., Cincinnati 15, Ohio. Bentyl® is dicyclomine and decapryn® is doxylamine.

severe drowsiness, a side effect previously described following use of decapryn.® In most cases, any mild sedation which might have been produced by bendectin® was probably helpful in controlling the symptoms and may, therefore, have been overlooked as a "side effect."

There was a period during which investigational supplies of the drug were not available. A number of patients were seen at that time and a variety of other medications were prescribed for control of nausea. Some of them had received bendectin® during a previous pregnancy and they complained bitterly about not having access to the same tablets. It was not possible to satisfy them with placebo tablets.

SUMMARY

Bendectin® is an enteric-coated tablet containing bentyl,® decapryn,® and pyridoxine. In dosage of one to three tablets at the hour of sleep or twice daily, it was completely effective in relieving nausea and vomiting in 179 of 205 patients (200 nausea of pregnancy; 5 due to other causes) and was partially effective in 25 others. Side effects were uncommon.

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Primary Diagnosis on Patients with Systemic Lupus Erythematosus

Following is a list of erroneous diagnoses recorded on patients at Johns Hopkins Hospital who were later shown to have systemic lupus:

1. Subacute bacterial endocarditis
2. Rheumatic fever
3. Various skin disorders
4. Latent syphilis
5. Raynaud's disease
6. Fever of undetermined origin
7. Glomerulonephritis
8. Epilepsy
9. Psychosis
10. Drug reaction
11. Functional illness
12. Idiopathic thrombocytopenia
13. Anemias of various types
14. Primary leucopenia
15. Virus pneumonia
16. Septicemia
17. Dermatomyositis
18. Lymphoma
19. Scleroderma
20. Tuberculosis
21. Brucellosis

—W. W. Woodward, M. D., Indianapolis, Ind.: *J. Kansas M. Soc.*, 58:43-46, January, 1957.

Antibody Response to Antirabies Vaccine

Although it is not too clear how the rabies vaccine confers immunity, it is generally believed that the antibodies produced neutralize and otherwise halt the spread of the virus through nerve tissue before it gains entrance to the vital neurons.

LeBell and associates noted that neutralizing antibodies and complement fixation antibodies began to appear at the completion of 14 daily injections of Semple type vaccine. A maximum production was reached four to five weeks later. They noted also that a lower antibody level was found in individuals receiving seven daily doses of vaccine. Other investigators have noted in a series of cases that response to the rabies vaccine usually occurs from the fourteenth to the twenty-first day of a 21-day course of vaccine therapy. Generally, adequate immunity against rabies can be expected clinically about the twelfth day after the completion of 14-day course of treatment with Semple type vaccine.

It is important to point out that the demonstration of antibodies (as ascertained by our present-day methods) is the only definite indication that the antigen induced by the rabies vaccine has been effective. However, the presence of antibodies does not always indicate that adequate protection against rabies virus has been produced. (At present there is no definite evidence available as to the quantitative levels of antibody necessary to protect humans against rabies.) In their evaluation of laboratory data of 29 persons bitten by a rabid wolf in Iran, Habel and Koprowski point out that among other complicating factors is the known fact that certain individuals produce antibody very poorly or not at all in response to any type of antigenic stimulus (rabies vaccine, rabies serum, or possibly from the antigen arising from multiplication of the natural virus introduced at the time of the bite.) Again, in this series of wolf bites these authorities note that of the five patients who only received a 21-day course of vaccine, two individuals failed to develop any demonstrable antibody during the period of observation which extended at least 10 days after completion of the course of 21 daily treatments. It is interesting to mention that one of these patients survived; the other died.

To the question occassionally raised as to the duration of immunity following 14 daily doses of vaccine, it may be stated that immunity undoubtedly lasts three months and perhaps six or nine months or up to a year. Unless a severe exposure has taken place within three months after vaccine therapy, immunizing agents are not indicated; between three to six months, serum (even when given later than 72 hours after the bite) followed by two doses of vaccine one week apart seems advisable.—Samuel Adams Cohen, M. D., New York City; *New York State J. Med.*, 57:1395, April 15, 1957.

The Thromboplastin Generation Test

Aids in the Study of Coagulation Defects—(No. 2)*

IN the April issue of *The Ohio State Medical Journal* the problem of defects in coagulation was touched upon with a discussion of plasma and serum prothrombin times, and their relation to the study of clotting defects. The place and limitation of such determinations in clotting defect studies was indicated and it was noted that there were other helpful tests available for problem cases.

In the instance of blood coagulation and hemorrhagic diseases, as in the instance of other complicated problems the problem can be simplified whenever new tools are provided. The thromboplastin generation test is such a tool—particularly valuable in the differential diagnosis of hemophilia from related diseases such as plasma thromboplastin component deficiency and plasma thromboplastin antecedent deficiency. The thromboplastin generation test is also very useful in making the broad decision as to whether or not a person is a "bleeder."

A brief review of a present concept of blood clotting visualizes three major steps or phases and perhaps two additional steps after them. The first step after injury to a blood vessel is the interaction of agglutinated platelets with antihemophilic globulin (AHG), plasma thromboplastin component (PTC), and plasma thromboplastin antecedent (PTA), overriding a natural circulating anticoagulant to form thromboplastin. In the second step of blood clotting, the thromboplastin changes prothrombin to thrombin with the help of calcium, plasma Ac-globulin (factor V), and serum Ac-globulin (factor VII). The third step is the formation of the insoluble fibrin clot from soluble fibrinogen by thrombin. A shrinkage or retraction of this clot by further platelet activity may be the fourth step. The fifth and last step is the lysis of the fibrin clot by a proteolytic or fibrinolytic enzyme previously dormant in the plasma.

USEFULNESS

The thromboplastin generation test will pick up a certain number of possible defects in this coagulation scheme. Particularly the test will be abnormal in deficiencies of anti-hemophilic globulin, plasma thromboplastin component, plasma thromboplastin antecedent or excess of circulating anticoagulant. Less importantly, the test is abnormal in deficiencies of plasma Ac-globulin (factor V or proaccelerin) and serum Ac-globulin (factor VII or proconvertin).

*Those desiring reprints of this article may secure them by writing to the Ohio Society of Pathologists, 267 E. Broad Street, Columbus 15, Ohio.

Submitted March 27, 1957.

The Author

● Prepared for the information of all Ohio physicians by the Ohio Society of Pathologists.

The thromboplastin generation test will usually not pick up defects in platelets, and actually the test has been much improved by using a platelet substitute (Bell and Alton, 1954) instead of a suspension of platelets.

TECHNIC

Rosemary Biggs and R. G. Macfarlane introduced the thromboplastin generation test in 1953. The test was based on the assumption that the natural thromboplastin generated during physiologic blood clotting is equivalent in potency to artificially extracted tissue thromboplastin. Biggs and Macfarlane devised a generation mixture as follows: (a) platelets obtained from the patient's blood or other sources; (b) prothrombin free plasma and serum from the patient under study and (c) calcium chloride solution. This is the test mixture. It generates a potent thromboplastin-like activity. The activity is measured by adding the mixture to a sample of known normal human oxalated plasma in the presence of a proper amount of calcium chloride solution.

In practice the generating mixture is sampled at intervals of 4 minutes, 8 minutes, 12 minutes, etc., until a minimal clotting time of normal plasma substrate has been established. Abnormality is indicated in two ways and usually both ways are manifested together. The total amount of thromboplastin generated may be inadequate and then the final clotting time with the normal substrate is prolonged. The thromboplastin may also be delayed in generation (a qualitative abnormality) and then the sample used giving the minimal clotting time with the normal substrate will be of high numerical value (12 or more minutes). In testing a normal human being a minimal clotting time of 10 to 12 seconds is reached in 4 to 8 minutes of generation. If hemorrhagic disease or coagulation defects are present in the subject, then the clotting time may be much longer than 15 seconds and the generating period longer than 12 minutes.

INTERPRETATION

The thromboplastin generation test is especially valuable in differentiation of defects of anti-hemophilic globulin, plasma thromboplastin component, plasma thromboplastin antecedent and

excess of circulating anticoagulants. By substituting normal plasma and normal serum fractions for the patient's plasma and serum in the test, these four entities can be separated. The prothrombin-free plasma fraction of the test should contain anti-hemophilic globulin, plasma thromboplastin antecedent, and factor V. The serum fraction of the test should contain plasma thromboplastin component, plasma thromboplastin antecedent and factor VII. Factor V and factor VII deficiencies are eleminated by the presence of a normal prothrombin time.

Correction of an abnormal thromboplastin generation time by substituted normal prothrombin-free plasma but not by substituted normal serum would indicate anti-hemophilic globulin deficiency; correction by normal serum but not by normal prothrombin-free plasma would indicate plasma thromboplastin component deficiency; correction by both plasma and serum would indicate plasma thromboplastin antecedent deficiency; correction by neither plasma nor serum would indicate an excess of circulating anticoagulant.

Essentially the same information is gained from the thromboplastin generation test as from the prothrombin consumption test (serum prothrombin time)—but the thromboplastin generation test is somewhat more sensitive and somewhat more accurate.

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Biological Type of Reaction Produced by Antibiotics

A most important type of undesirable reaction produced by antibiotics usually is referred to as "biological." Administration of the drugs (particularly those of the "broad spectrum" type) for the purpose of eradicating disease-producing bacteria can result also in destruction of many of the saprophytic microbial inhabitants of the skin and mucosal surfaces, the normal flora of the body. The remaining microorganisms, oftentimes resistant staphylococci, then are able to multiply, to overgrow the body surfaces and, frequently, to produce so-called superinfections.

The production of superinfection by resistant staphylococci or more unusual microorganisms can lead to disease more serious than that for which antibiotics originally were prescribed. This type of reaction, long recognized but thought to be relatively infrequent, has been shown by Weinstein to occur rather commonly, particularly in children, and to result as often from therapy of brief duration as from that consisting of prolonged administration of large doses.—Ivan L. Bennett, Jr., M. D., Baltimore, Md.: *West Virginia M. J.*, 53:55-62, February, 1957.

Agammaglobulinemia and Abnormal Globulins

Agammaglobulinemia was originally recognized by Bruton in 1952 and was quickly established as a clinical entity by Bruton, Janeway and co-authors. Since these early descriptions more than 50 cases of this syndrome have been reported. Many of these patients have been carefully studied to delineate further the clinical features and the immunologic deficits, and to clarify the basic mechanisms of antibody production. The purpose of this communication is to review briefly the current concepts of these diseases.

The gamma globulin fraction was so named because its migration in the Tiselius electrophorectic apparatus was the slowest of the three globulin components. Although not all the constituents of this component have been identified, it is known that most of the circulating antibodies are gamma globulins. If this antibody-containing material were deficient or absent one might anticipate enhanced susceptibility to infection. This appears to be the case in agammaglobulinemia.

The term *agammaglobulinemia*, which has already become firmly entrenched, is a misnomer. General usage has defined it as the absence of gamma globulins by electrophoretic methods. However, it has been demonstrated by immunologic techniques, which are much more sensitive, that small amounts of gamma globulins (2-100 mg. per 100 cc.) are present in these cases. Nevertheless, the name congenital agammaglobulinemia is universally accepted. There is, however, a growing tendency to refer to the acquired types as hypogammaglobulinemia.

Congenital agammaglobulinemia, the disease originally described, and acquired agammaglobulinemia, a related disorder which was recognized subsequently, are the most important clinically. Of less importance are a variety of diseases associated with hypogammaglobulinemia. A provisional classification of these syndromes is presented, based on the approximate amounts of gamma globulin present. . . . This classification is arranged to emphasize that these entities form a wide spectrum of disorders of protein metabolism, ranging from almost complete absence of gamma globulin to gross hypergammaglobulinemia.

The recognition of these clinical syndromes and their underlying defects have greatly extended our knowledge of immunologic mechanisms.

The significance of agammaglobulinemia transcends the handful of unfortunate patients who develop this disorder. Viewed as a discrete metabolic abnormality, this disease serves as a stimulus and a tool for investigation of some of the basic problems of protein metabolism and antibody production.—Harold O. Conn, M. D., New Haven: *Connecticut Medical Journal*, 21:233, March, 1957.

The Recalcitrant Tuberculous Patient*

H. J. NIMITZ, M. D.

The Author

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DEFINITION

WEBSTER'S INTERNATIONAL DICTIONARY defines "recalcitrant" as "stubbornly rebellious; obstinate in defying constituted authority."

The recalcitrant tuberculous patient meets this definition. He is uncooperative, repeatedly leaves the tuberculosis hospital against medical advice, refuses to remain hospitalized for the length of time necessary to bring his disease under control, and in many instances creates administrative problems during his hospital stay. The vast majority of recalcitrant patients are alcoholics, individuals with psychopathic personalities, or persons of low mentality. It is difficult to reason with such patients, to discuss their cases with them intelligently, and to educate them as to their responsibilities to themselves and to the public. Recalcitrant patients definitely constitute a public health menace and, as such, become one of the biggest problems in tuberculosis control.

THE PROBLEM

A few years ago, when there were waiting lists for most tuberculosis hospitals, uncooperative patients were permitted to leave against medical advice without too much regret on the part of the hospital staff, who knew from past experience that such patients become increasingly difficult and demanding. Also, a cooperative patient with perhaps a more serious problem was readily available to occupy the vacated bed. At that time, due to the lack of tuberculosis hospital beds, public health authorities could do little to protect the public other than to place the names of recalcitrant patients back on the waiting lists for readmission.

Today, the situation is entirely different. Through the widespread use of antimicrobial drugs and improvements in surgical procedures, hospitalization has been so shortened that waiting lists are practically nonexistent and empty beds are available in most tuberculosis hospitals.

Unfortunately, 25 to 50 per cent of all discharged patients leave tuberculosis hospitals in the United States against medical advice. Tuberculosis hospitals set up standards which they feel must be met before a patient is given a regular discharge. Certainly, not all patients who leave against medical advice are considered recalcitrant. Some patients, with negative sputum, leave after several months to continue their convalescence and treatment at home under supervision of their private physician or a Chest Clinic.

A high percentage, however, of those who leave against medical advice *are* recalcitrant patients. Those who are considered recalcitrant are active cavitary cases who have been habitual offenders in repeatedly leaving hospitals. They have been uncooperative and demanding while in the hospital, have refused to take bed rest or antimicrobial therapy when offered, and have disregarded all public health rules and regulations when not hospitalized. Such patients constitute a public health menace to their families and to the general public.

Another group of recalcitrant patients has never been in a tuberculosis hospital because of the refusal to accept either the diagnosis of active tuberculosis, or hospitalization for treatment.

A TYPICAL EXAMPLE

Last year (1955) Dunham Hospital (Hamilton County Tuberculosis Hospital) discharged 447 patients. Of this total, 164 were discharged against medical advice (36.5 per cent). This is not a record of which to be proud, but still within state and national averages. Of the 164 patients discharged against medical advice, 63 had previously been patients here. On careful examination of the records of all 164 patients, it was concluded that 21 of them fell into the recalcitrant category. Practically all of these 21 patients had from one to five commitments in the City Isolation Hospital for short periods before they were readmitted to Dunham Hospital.

At the present time, it is safe to say that 10 to 15 per cent of all patients who leave tuberculosis hospitals against medical advice, and 35 to 40 per cent of readmission patients discharged against medical advice are recalcitrant.

Many years ago, it was concluded after careful studies, that 85 to 90 per cent of the blame for patients having tuberculosis in the advanced stages could be charged to the patients themselves. This still holds true. Self-neglect by patients is a manifestation of ignorance. Too many tuberculous patients leave our hospitals

*This is one of a series of articles on chest diseases sponsored by the Ohio Trudeau Society, medical section of the Ohio Tuberculosis and Health Association.

Submitted December 5, 1956.

against medical advice only to return with difficult or hopeless complications. Our public health education programs have not solved the problem and still leave much to be desired.

Tuberculosis can now be successfully treated. It is a social outrage and a public health disgrace when anyone with an infectious active case of tuberculosis is allowed to walk our streets today.

THE LAW

Effective August 5, 1955, the State Legislature passed House Bill No. 127: "To protect the public from persons with communicable tuberculosis." This law gives the board of health of the city or county the power to deal with recalcitrant tuberculous patients.

NECESSARY ACTION

It would seem advisable that larger communities develop and use isolation hospitals in city workhouses for long term isolation and complete treatment in handling their local recalcitrant patients (which we intend to do). Counties without such facilities should use State quarantine hospitals for this purpose. In the past, too many recalcitrant patients have been coddled, pampered, and their actions excused. We need positive action to protect the public.

At state and national tuberculosis meetings we have had to listen to various workers make excuses for the recalcitrant patient. What they have advocated as "educating the patient, etc." has not solved the problem—it continued to get worse. *Therefore, a heavy burden of responsibility rests on individuals who, through devious ways, confuse the issue of isolating the recalcitrant patient*—a major problem in tuberculosis control.

I heartily agree with the public health official who stated: "Now don't quote me as saying that every person with tuberculosis should be locked up, but a few *should* be locked up, and if facilities for such action existed, many cases of tuberculosis could be prevented."

The public should be educated to a sympathetic understanding of the necessity for isolation or quarantine of every recalcitrant patient who constitutes a public health menace, so that it will demand that public health officials enforce the law. We should be constantly mindful of the fact that INDIFFERENCE, not opposition, is the greatest foe of progress in tuberculosis control.

Mumps Reported in 1790

Hamilton in 1790 presented one of the first formal reports of "A Distemper, By the Common People in England Vulgarly Called the Mumps." In this very carefully written report he described the usual course of this disease and stressed the frequency of central nervous system involvement. —Henry B. Bruyn, M. D., et al., San Francisco: *California Medicine*, 86:153, March, 1957.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Tremor—This term has been used by physicians from ancient to modern times to denote an involuntary trembling or quivering. It is a Latin word which has come unchanged into English and means a shaking and comes from the Latin "tremo,"—"to shake."

Trabecula—A descriptive term, literally meaning a "little beam or timber," which is used in anatomy to designate a strand or septum of supporting fibers. Trabecula is the diminutive of the Latin word "trabs," meaning "a beam or timber."

Scrobutus—This is not a true Latin term but is a Latinized form of the English term, "scurvy." It was an attempt on the part of physicians to dignify a lay term.

Fulguration—This term designating the surgical destruction of tissues by means of electric sparks is derived from the Latin word "fulgar," meaning a flash of lightning. This in turn comes from the Latin word "fulgeo," meaning "I gleam."

Fugue—Coming from the Latin word "fugio" meaning to flee, this is a descriptive term which is used in psychiatry to denote a state of amnesia of considerable duration which involves a flight from familiar surroundings.

Frenzy—This term designating a violent mania is a corruption of the older spelling of this word which was "phrensy." This is derived from the Latin and Greek word "phrenesis," meaning madness or delirium, and in turn comes from the Greek word "phren," or mind.

Fourchette—Literally meaning "a little fork," this French word is the diminutive of the French word "fourche" or fork, which in turn comes from the Latin "furca" designating a two-pronged fork. This term was introduced by Francois Mauriceau a seventeenth century French obstetrician. He descriptively applied it to a fold of mucous membrane just inside the posterior commissure of the vulva.

Glisson's Capsule—This is the fibrous capsule of the liver and it was described in 1654 by Francis Glisson, an English physician, in his book on the liver entitled *De Hepate*.

Gubernaculum—A Latin word, meaning "a helm or a rudder," and which has been descriptively applied in anatomy to a guiding structure. The gubernaculum testis was described in 1784 by the English anatomist William Hunter. It is a fibrous cord extending from the fetal testis and occupying the potential inguinal canal and serving to guide the testis in its descent.

Gravid—This rather obsolete term, literally means to be heavy with child and is derived from the Latin word "gravis," or heavy.

—HARRY WAIN, M. D., Mansfield, Ohio.



A CONTINUOUS state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and assisted by official representatives of the various County Medical Societies of the state.

Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, will be published in *The Ohio State Medical Journal* from time to time. Each presentation will be brief but informative. It will contain opinions of the Committee, based on the data submitted for review. In the series of cases entitled "Other Causes," the four cases in this tenth report have to do with maternal death due to infection, the result of (alleged) criminal abortion.

CASE NO. 16

This patient was a 30 year old white female who died 34 hours and 15 minutes after admission to the hospital. Nothing is known concerning her past history or the number of previous pregnancies. Her last normal menstrual period was December 22. On February 23 the patient was admitted with the complaint of dyspnea and her history revealed that she had allegedly been criminally aborted within the past 24 hours. Three hours before admission she began to bleed and collapsed at noon. She was admitted in shock with a blood pressure of 90/42, pulse 128 and irregular respirations. Her temperature was 101 by rectum and she appeared critically ill.

Details of physical examination upon admission are not obtainable. However, her treatment consisted of antibiotics, benadryl,® nasal oxygen, intravenous fluids and whole blood. Later digitalis and serum albumin were administered. In spite of treatment the patient pursued a downhill course, developed Cheyne-Stokes respiration, and died on the 25th of February. Autopsy permission was obtained.

Cause of death: Pulmonary edema, infected uterus, and (alleged) criminal abortion.

Pathological diagnosis: Acute endometritis, parametritis and thrombophlebitis of pelvic plexus of veins; acute passive congestion and parenchymatous degeneration of all organs; marked pulmonary edema and congestion with bronchopneumonia.

COMMENT

After careful study of the facts available in this case, the Committee voted this a preventable death P_1 following an alleged criminal abortion. Apparently the patient died in spite of adequate and prompt treatment after her hospital admission.

CASE NO. 51

This patient was a 27 year old white gravida V, Para III, abortus II, who died one hour and forty-two minutes after admission to the hospital. In her past history there was allegedly a criminal abortion performed previously. The patient was admitted to the hospital June 30, reporting her last menstrual period had occurred in January. She was comatose but the husband stated that she had signs of bleeding, chilling, abdominal pain, swelling and nausea for three days previously. No medical help was obtained until she was brought to the hospital in extremis.

Details concerning her treatment were not available but therapy consisted mainly of antibiotics and supporting therapy. In spite of these the patient died the same day. Autopsy permission was obtained.

Cause of death: Acute necrotizing cervicitis, endometritis, myometritis secondary to abortion (allegedly) induced, criminal.

Pathological diagnosis: Acute necrotizing cervicitis, parametritis and myometritis; multiple sinuses arising from cervix into peri-cervical and retroperitoneal tissues with generalized retroperitoneal cellulitis and acute peritonitis secondary to parametritis; acute pulmonary edema; visceral evidences of septicemia.

COMMENT

In spite of the meager information available on this case, based on available information the Committee voted this death preventable, P_1 allegedly induced abortion.

CASE NO. 52

This patient was a 28 year old white gravida V, Para III, abortus I, who died 21 days after her admission to the hospital. Her past history revealed that she had had tuberculosis previously but was recovered. The patient was admitted to the hospital on June 20 with the history that she had allegedly had a criminal abortion performed two months previously. Following this, she had a septic course with profuse vaginal

bleeding. Her family physician treated her with antibiotics which apparently improved her condition temporarily. However, her condition became worse and she was finally admitted with a diagnosis of anemia and septicemia and also right pneumothorax. During her hospital course a thoracotomy was performed and she received extensive antibiotic sensitive studies with therapy and heroic supportive treatment. In spite of this, she continued a septic course and expired on July 11. Autopsy permission was obtained.

Pathological diagnosis: Acute endometritis and secondary thrombosis of the right uterine and ovarian arteries and veins; multiple septic pulmonary emboli and septic pulmonary infarctions; acute ulcerative vegetative endocarditis and mural thrombus; hemopericardium; generalized subcutaneous emphysema; thoracotomy wound right chest.

COMMENT

After a review of factors in the case, the Committee voted this a preventable death P_1 allegedly induced abortion. Although details concerning the etiological organism of the pulmonary process were not available, it was believed that this was a horribly extensive process which resisted all means of therapy.

CASE NO. 115

This patient was a 29 year old white, gravida IX, Para V, abortus III, who died 15 hours and 43 minutes after admission to the hospital. Her past history is not remarkable except that she had had three curettments, each following a previous abortion. Her last menstrual period was in October. She was admitted to the hospital December 25 in a severe state of shock with pain in the lower abdomen and back.

Details concerning the alleged criminal abortion were not available. However, upon admission the patient had a temperature of 101° with a blood pressure of 101/90. Her white blood count was 22,200 with a hemoglobin of 66 per cent, 3,500,000 red corpuscles. She had albuminuria and occult blood in the urine. Vaginal examination revealed a bloody discharge, swelling, a dilated cervix and a complete retroversion. Treatment consisted of demerol,® combiotic,® two units of blood, intravenous glucose, chloromycetin,® terramycin,® adrenalin® and oxygen. In spite of treatment the patient died the following day. Autopsy permission was not obtained.

Cause of death: Fulminating sepsis, (alleged) self-attempt to induce miscarriage by using pencil.

COMMENT

The Committee studied this case with a great deal of interest and realized that it was obviously one dealing with fulminating infection. Heroic attempts with various forms of therapy proved fruitless. The Committee voted this case a preventable death P_1 alleged attempt at self-induced abortion.

Chloral Hydrate is a central nervous system depressant, producing a very normal physiological sleep. There are no after effects and no untoward effects in other tissues. It remains one of our most effective hypnotics. The capsule form is very convenient to use.—*Arizona Medicine*, 14: 143, March, 1957.

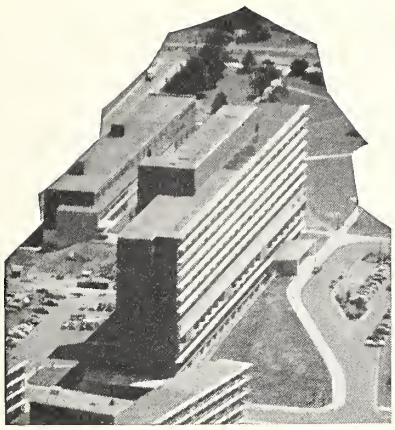
The Papanicolaou Smear Technique To Detect Early Cancer In Cervix Uteri

If cancer of the cervix is to be detected early, it is in the general practitioner's office where it should first be found. Now, with the "Pap smear" technique available to any doctor, it is entirely possible and practical, and I might say, morally mandatory, that the general practitioner take the trouble to use this method, and with the help of a good pathologist, roentgenologist, and surgeon, make far advanced cancer of the uterine cervix, in patients who give him the opportunity, a thing of the past.

It is apparent, or should be apparent, to anyone who has looked at many uterine cervices that, from the standpoint of detection of early cancer of the cervix, the appearance of the cervix means nothing. Lacerations, erosions, granulations, polyps, cysts, and exudates, might make one suspicious, but, oftener than not, these abnormal-looking cervices do not turn out to be malignant. But when you see a relatively normal-looking cervix and get a "Pap smear" of it showing Class III cells, followed by a biopsy showing carcinoma in situ, or early invasive stage, you are impressed with the efficacy of this method of detection. How else would such a patient ever have been led to early treatment and probable cure? This is the type of case that makes it imperative and morally obligatory to do a "Pap smear" on every cervix examined. It has been said that one case proves nothing; but, in this instance, at least for this patient, one case is all that is needed to save her very life, and for her and for me, it is all that is needed to prove the efficacy of the use of the "Pap smear" technique for this particular cancer in this particular location. . . .

It should be said that the technique of obtaining a "Pap smear" and treating it and preserving it until the pathologist gets to it is all-important in evaluating any results of studies—the "Pap smears" in this study were obtained, processed and preserved according to the method described in the film on "Precancer Diagnosis of the Cervix by Cytology," by the American Cancer Society, obtainable for showing to professional groups.

The study includes 491 "Pap smears" obtained on 360 patients. Of these 491 smears, 399, or 81.3 per cent, were reported as showing Class I cells; 51, or 10.4 per cent, were reported as showing Class II cells; 36, or 7.3 per cent, were reported showing Class III cells, and 5, or 1 per cent, showed Class IV and Class V cells. . . . All five of this group were biopsied, and there were four malignancies found. I should state here that the biopsy of the one patient whose Class IV cells came from a normal appearing cervix, was one of the positive biopsies, showing intra-epithelial carcinoma.—Robert P. Acher, M. D., Greensburg: *J. Indiana M. A.*, 50:441, April, 1957.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Ralph J. Johansmann, M. D., President

Presented by Richard H. Freyberg, M. D., Cornell University,
and Emmerich von Haam, M. D.

Edited by Dr. von Haam

PRESENTATION OF CASE

A WHITE male truck driver was first admitted to the University Hospital at the age of 43 with the chief complaint of a skin rash and increasing weakness. The skin rash had first developed one and a half years previously after a period of severe sore throat and the patient had suffered a 13 day period of complete anuria during this episode. The skin rash returned one year later on the arms, buttocks and legs and was tentatively diagnosed as pemphigus at this time. The lesion was crusting, exudative and erythematous and later also involved the nares, upper lip and chest. A skin biopsy showed nonspecific inflammation.

The patient also gave a brief history of arthritis, complaints of mild ankle edema and symptoms of a mild chronic cough. He drank 8 to 10 beers a day. The patient was febrile during the first eight days but all attempts to locate an infection were futile. He was discharged to the Clinic but was readmitted on three occasions during the same year because of flareups of his skin rash. A liver and lymph node biopsy revealed no specific lesion and no LE cells were seen in the bone marrow.

Typhoid vaccine therapy administered on his fourth admission brought considerable improvement of his skin rash but he developed a marked hematuria and therefore was readmitted for the fifth time. His blood pressure now had risen to 192 over 102 and he excreted 2,000 mg. of protein in 24 hours. His blood urea nitrogen rose to 77.5 mg., his creatinine was 11.2 mg. and his phenolsulfonphthalein test showed only a 15 per cent excretion in two hours. His heart shadow revealed 93 per cent increase in size and the patient showed for the first time a moderate orthopnea and dyspnea. This improved on digitalis therapy but the hematuria persisted and his hemoglobin dropped to 8.3 Gm., necessitating some blood transfusions.

He was started on cortisone therapy and improved so markedly that he was discharged on 0.1 mg. digitalis, 100 mg. cortisone and a low sodium diet. His blood pressure returned to 160 over 80 and his blood urea nitrogen stabilized at around 70 mg. Subjectively the patient felt extremely well and his cortisone was discontinued three months after his discharge. He remained fairly well for the next two years.

Two months before his sixth and last admission he became progressively dyspneic and developed fullness in the abdomen and pedal edema. He reported slight yellowing of his skin at intervals over the last three to four months. The stools were slightly lighter in color than normal but were regular. He had no chills, fever or night sweats at this time. There was also some "purpura" appearing on the ankles during the last week. He denied hemoptysis, hematemesis or bloody stools. He had had some intermittent hematuria during the interval between the last hospital admissions.

PHYSICAL EXAMINATION

Physical examination revealed a blood pressure of 110 over 80, pulse 96, respirations 28, temperature 98.8 F. The fundi showed a Grade I arteriosclerotic retinopathy. There was scarring of the right ear drum. There was slight venous distention of the neck veins on orthopneic position. The chest showed increased anteroposterior diameter. The lungs showed a diminished percussion note at the bases posteriorly. The heart was described as enlarged to the left, filling the entire left lower chest. There was a Grade II high-pitched soft diastolic murmur over the

Submitted February 26, 1957.

aortic area and a Grade II rough short systolic murmur heard best at the aortic area. There was also a Grade I systolic murmur heard at the apex.

The liver was enlarged to the umbilicus, slightly tender and nonpulsating. The spleen was not palpable. There was thought to be ascites present. The bowel sounds were normal. Femoral pulses were of good quality. There was no abdominal tenderness and no costovertebral angle tenderness. The extremities showed purpuric spots on the feet, ankles and legs and Grade III pitting edema bilaterally. There was questionable jaundice of the skin and a diffuse alopecia. No spider nevi were seen. Neurological examination was negative. The prostate was moderately enlarged.

X-RAY EXAMINATION

The chest x-ray showed the heart to fill almost the entire lower thorax, going to the lateral chest wall on the left. The aorta was tortuous and elongated and the lung fields were visible and not remarkable. Repeat x-rays of the chest after the pericardial tap showed an air-fluid level and still considerable fluid remaining.

LABORATORY DATA

The urinalysis showed a yellow hazy urine with a specific gravity of 1.009, a *p*H of 4.5, and a protein content of 40 mg; tests for sugar, acetone and diacetic acid were negative; the microscopic examination showed occasional white blood cells per high power field, no red cells. The white blood count showed a total number of 13,300 cells with 77 per cent neutrophils; the red blood count was 3 million with a hemoglobin of 9.9 Gm.; the platelet count was 117,000; the sedimentation rate was 30 (corrected, Wintrobe). Stool was guaiac-positive. The inorganic phosphorous was 9.6 mg., the alkaline phosphatase 5.5 units, the acid phosphatase 0. Total serum protein was 8.4 Gm. with an albumin of 3.2 and a globulin of 5.2.

Determination of the serum electrolytes showed 139 mEq. of sodium, 6.5 mEq. potassium and 99 mEq. of chlorides. The van den Bergh reaction was 0.1 mg. direct and 0.4 mg. indirect; the thymol turbidity test was 50; the prothrombin content was 45 per cent; the cephalin flocculation test was 3 plus. The test for C-reactive protein was also 3 plus. The total serum cholesterol was 135 mg. with 77 per cent esters. The CO_2 combining power was 43 vol. The blood urea nitrogen was 130 mg., the creatinine 5.5 mg., and the uric acid 7.7 mg.

Electrocardiogram showed myocardial changes consistent with a resolving pericarditis.

HOSPITAL COURSE

The patient continued in a markedly dyspneic state throughout his short hospital stay. On his first hospital day a pericardial tap removed 500 cc. of serosanguineous, nonclotting fluid. The patient withstood the procedure well. On his second hospital day the patient developed severe dyspnea and nasal oxygen was started. He also complained of a rather severe chest pain which was not relieved by demerol.® He became very agitated and was sedated with chloral hydrate. Several hours later he was found dead.

CLINICAL DISCUSSION

DR. R. H. FREYBERG: The person we are discussing was a healthy, vigorous male laborer with multiple complaints that changed from time to time during the course of his long illness and repeated hospital studies. Prominent among these complaints were skin eruptions and weakness, which were the first symptoms that made him go to the doctor. It is interesting that some years ago he was said to have had a 13 day period of anuria. The biopsy of his skin was reported as a nonspecific inflammatory reaction, which I interpret as inflammation which did not permit the allocation of a definite etiologic agent. I was a little surprised that they made a clinical diagnosis of pemphigus, but at one time it may well have had some of the characteristics of pemphigus. All searches for LE cells in the blood and bone marrow were negative.

The patient also gave a brief history of "gouty arthritis," but I find nothing that would make me think that this patient had gout or a disease based upon gout. From early in the course of his illness the patient noted purpuric spots on his skin, which would indicate to me that he had been bleeding either from a vascular or a hemorrhagic disease. At various intervals he had short periods of fever and with the fever he developed tachycardia and ankle edema. The gallop rhythm of his pulse and the variety of murmurs heard over his heart suggest that this organ too was involved in the disease process. He obviously drank too much and this again will implicate the liver, which was found to be enlarged.

So in summary we can suspect that the patient had some sort of dermatitis, a diseased heart, possibly cirrhosis of the liver (he had an abnormal liver), and perhaps some form of vascular disease. From the laboratory studies we must conclude that the patient also had renal disease, probably glomerulonephritis. His urinary findings as well as his blood chemistries are in support of such a diagnosis. In addition he had a severe anemia and a hyperglobulinemia. His elevated uric acid content should be interpreted in light of his liver disease and kidney disease, and without other clinical evidence is not sufficient support for a diagnosis of gout.

All blood cultures were negative, and so were tests for myeloma and other neoplastic diseases. The patient had definite benefit from ACTH and from corticosteroids. It is difficult to interpret why one is benefited from corticosteroids, and it is not a therapeutic test that would allow one

to make definite deductions as to what kind of disease the patient had because it affects favorably many different illnesses. But it would make one somewhat suspect at least that the patient had a form of connective tissue disease which we know is commonly much improved with the use of corticotropins.

FOURTH ADMISSION

On his fourth hospital admission typhoid vaccine therapy was attempted and if anything it made the patient only worse, although his skin rash responded favorably to the fever. But he had a great deal more hemorrhage from the kidneys and when he came into the hospital for the fifth time he had renal hypertension and clinical evidences of cardiac failure. The blood pressure elevation can be attributed to aggravation of his nephritis, while his other symptoms must be explained by changes in the dynamics of his heart function since they responded to the treatment usually effective for congestive failure. So I feel certain that his edema, his ascites, part of his liver enlargement, the rales in his chest and the cardiac enlargement were at least in part due to cardiac failure.

He became worse rapidly, as indicated by all the clinical symptoms. His anemia increased and his renal function decreased to the point of renal insufficiency with blood urea nitrogen retention. The high specific gravities in the urine at that time must be explained by the high protein content of the urine, and one would need to have a nonprotein specific gravity in order to draw any conclusions upon the functional status of the kidneys. Again the patient improved markedly after rather large amounts of cortisone, which would make one feel strongly that his disease was of the nature of a diffuse connective tissue disease.

LAST ADMISSION

The sixth and last admission to the hospital came after a period of two years, and I think it is rather surprising that this patient got along as well as he did after as severe a bout of illness as he had, with so many vital organs involved. Then he came back again with the usual signs of mounting cardiac failure, with increasing degree of orthopnea, paroxysmal nocturnal dyspnea and various other symptoms that would be expected with congestive failure. Again there was some purpura on his legs, so we can again suspect some peripheral vascular disease that would allow capillary bleeding and intermittent hematuria.

Sometimes with a diffuse collagen disease or a vascular disease you may see the evidence of it by examination of the vessels of the fundi. You will see the lesions only if the retinal vessels participate in the disease and if you do not find them it does not disprove vascular collagen disease. The examination of his fundi showed only a Grade 1 retinopathy and nothing specific for an acute vasculitis. Otherwise the patient showed first evidence of decrease of his cardiac function, more severe anemia and increased renal insufficiency. He died rather suddenly one day after removal of 500 cc. of fluid from his pericardial sac. His death, which occurred rather unexpectedly within 24 hours after his pericardial effusion was aspirated, makes one wonder whether he may have hemorrhaged into the pericardial sac with cardiac tamponade, or whether he had a sudden dilatation of the heart which caused cessation of cardiac function.

So to summarize then, we can say that this patient over the period of his long illness suffered from clinically obscure types of dermatitis, myocarditis, pericarditis, hepatitis or cirrhosis, and arteritis with lymphadenopathy, nephritis, anemia, hyperglobulinemia; who later developed cardiac and renal failure with a pericardial effusion. He improved greatly at times with corticosteroid therapy and died suddenly after aspiration of fluid from his pericardial sac.

INFECTION?

There was never any evidence that his illness was produced by an infection of any kind, and the involvement of those three important organs—heart, liver and kidney—would let me suspect that this patient had a diffuse connective tissue, or if you wish, collagen disease. It may have been primarily a disease of the vascular collagen, like periarteritis, or it may have been more the type of lupus erythematosus or scleroderma.

Against lupus erythematosus speak the failure to observe LE cells, and the patient's symptoms do not agree with scleroderma or dermatomyositis. He also did not have the clinical features of rheumatoid arthritis. I feel that he had a collagen disease which for want of further localization we would call undifferentiated diffuse connective tissue disease. To me it makes really little difference what special label is put on this disease as long as we understand as doctors the nature of the disease and manage the patient accordingly.

For example, what justification have we for calling this a case of diffuse lupus erythematosus when repeated tests which we consider rather reliable always failed to show the LE phenomenon? Clinically, however, this patient went through a course which was quite characteristic of diffuse lupus except that he did not have the typical dermatitis of lupus erythematosus. I think these names we use for the various types of collagen disease leave much to be desired. Why should we call a disease which has its fatal effect on the connective tissue of all organ systems by a name that refers to a dermatitis that many patients don't have?

I think that periarteritis nodosa might be a good clinical possibility but I do not think that we need to assume that this arteritis is strictly

"peri" or nodular. It could be a diffuse polyarteritis that affects vessels of certain but not all organs and wherever it appears it is bound to affect greatly the functional status of the organs involved. We may confirm the diagnosis by biopsies, but again a negative biopsy does not exclude the diagnosis.

With regard to dermatomyositis, we agree that he had dermatitis but we don't have any clinical evidence that he had myositis, and again that is just a poor name for a diffuse and fatal connective tissue disease. If we use it, it must only imply that the predominant clinical manifestations were in the muscle and the skin, and that certainly was not demonstrated in our patient. He died with heart, kidney and liver disease and the consequences of systemic manifestations, so that I would prefer not to be so specific and for the sake of correctness say that he suffered from a diffuse connective tissue disease and that we have no clinical evidence to differentiate it any further.

CLINICAL DIAGNOSIS

1. Diffuse undifferentiated collagen disease.
2. Pericardial effusion.
3. Myocarditis.
4. Hepatic cirrhosis.
5. Chronic glomerulonephritis.
6. Sudden death due to acute cardiac tamponade or acute myocardial dilatation.

PATHOLOGIC DIAGNOSIS

1. Diffuse collagen disease with:
   - *a* Polyserositis.
   - *b* Lupus erythematosus.
   - *c* Lesions of spleen and kidney.
2. Healed rheumatic heart disease with:
   - *a* Calcific aortic stenosis.
   - *b* Left ventricular hypertrophy.
3. Massive atelectasis of right lung.
4. Mild hepatic cirrhosis.
5. Chronic glomerulonephritis.

PATHOLOGIC DISCUSSION

Dr. Emmerich von Haam: Thank you very much, Dr. Freyberg. Your broad concept and classification of collagen diseases was quite a revelation to me. You see, we always read of lupus without lupus and periarteritis which really is not strictly periarteritis, and still we are called upon to subdivide collagen disease into all three varieties, as you mentioned. Dr. Klemperer's thorough case study contains all imaginable combinations of collagen disease types and still the pathologist is asked by the clinician to pigeonhole these disease entities which really belong in one great big group.

Now as far as our patient is concerned, I do fully agree with Dr. Freyberg that we are dealing here with a type of collagen disease. The autopsy showed a severely cyanotic patient with moderate edema of the lower extremities. His skin lesions, however, were barely distinguishable and consisted of a pale scaly roughness distributed over the lower extremities. He had fluid in all serous cavities: 1,300 cc. in the pleural cavities, 900 cc. in the abdomen and 400 cc. in the pericardial cavity.

His heart was greatly enlarged and weighed 860 Gm. The valve leaflets of the aortic valve were deformed and calcified and the ostium of the aortic valve was markedly stenosed. The left ventricle was hypertrophied, both ventricles were greatly dilated, and the pericardium was acutely inflamed.

The lungs were atelectatic, airless, compressed and edematous. The spleen was slightly enlarged but probably was not clinically palpable. The liver was normal in size and showed a slight nutmeg pattern. The gastrointestinal tract was congested. The kidneys were pale, small and finely granular. Grossly we thought of chronic glomerulonephritis, old rheumatic heart disease and possibly lupus erythematosus of the skin.

MICROSCOPIC EXAMINATION

Sections through the skin showed changes which were quite typical of subacute lupus erythematosus. They consisted of epithelial atrophy with the formation of keratin plugs, liquefaction necrosis of the subepidermal collagen fibers, and hyaline necrosis of small blood vessels with an acute polyvasculitis. The previous biopsies showed only nonspecific inflammation in the subepidermal layer which I could not recognize as lupus.

Sections through the heart showed swelling and hyalinization of the collagen of the pericardium and many hyaline scars in the myocardium, but no acute myocarditis. The valvular changes were compatible with a healed rheumatic endocarditis although again hyalinization was more pronounced than fibrosis. The lungs showed again fibrinous and hyaline degeneration of the subpleural collagen with some pressure atelectasis of the lower lobes. The microscopic picture of the spleen showed the thick onion-skin-like hyaline rings around the trabecular vessels which are so characteristic of lupus.

The liver showed less severe changes than Dr. Freyberg expected. The fellow drank only beer, after all. There was a hyalinized fibrosis of the periportal tissues with intact central veins and no histological evidence of portal hypertension. The changes of the liver in collagen diseases are rather ill-defined and I cannot say whether those observations were significant. Sections through the kidneys showed marked thickening of the wall of the arterioles—evidence of marked hypertension. There was, however, no vascular necrosis or thrombosis, which rules out malignant hypertension.

The capillaries of the glomeruli were reduced in number and showed marked hyaline thickening of their membranes, thus producing the classical picture of "wireloop" glomeruli. Some

glomeruli were completely hyalinized, others showed fibrosis with capsular adhesions. The tubules contained blood casts. The entire histological picture appeared less severe than the marked degree of renal failure would let one expect, and we must assume that glomerular ischemia rather than glomerular destruction was the outstanding factor responsible for his renal failure. Sections through the bone marrow and the lymph nodes showed many areas of focal necrosis with many so-called hematoxylin bodies, which findings again are typical of collagen disease of the capillaries.

In summary then I would say that this patient showed microscopically features of several conditions. He showed evidence of an old rheumatic fever with chronic glomerulonephritis and a more recent and widespread collagen disease characterized by polyserositis, lupus of the skin and vascular changes in liver, spleen, kidneys and bone marrow. I am anxious to have Dr. Freyberg comment upon these lesions and tell us what they represent.

DR. FREYBERG: Those are excellent demonstrations of the histological changes that are so characteristic of a diffuse collagen disease, and whether you want to call it lupus erythematosus disseminatus or some other name that implies the localization of these changes, like periarteritis, is quite optional. The important thing is that we are dealing with a diffuse disease of collagen connective tissue characterized by degenerative, necrotic and inflammatory changes in various vital organs.

I want to emphasize that this disease goes through definite changes, and when you examine various tissues at various times during the course of the disease you may get varying pictures, as this case demonstrates. The doctors did not find the changes in the various biopsies that Dr. von Haam has demonstrated, otherwise the clinical diagnosis would have been much simpler.

Action of Amphetamine

Amphetamine is a form of medication which stimulates the higher nervous centers. There is no explanation for the stimulation of the brain which occurs when it is used. The psychic effects depend on the mental state and the personality of the patient as well as the dose which is given.

Its use in weight reduction is dependent upon the reaction of the brain to refuse foods. Apparently tolerance does not develop. It is also of great use in the treatment of narcolepsy and post encephalitic Parkinsonism.

Amphetamine is wonderful in the treatment of mood disturbances, but poor in the treatment of a true psychoneurosis. Many different recent preparations are available.—L. Maxwell Lockie, M. D., Buffalo, N. Y.: *Arizona Medicine*, 14:143, March, 1957.

Stresses Need for More Medical Historians

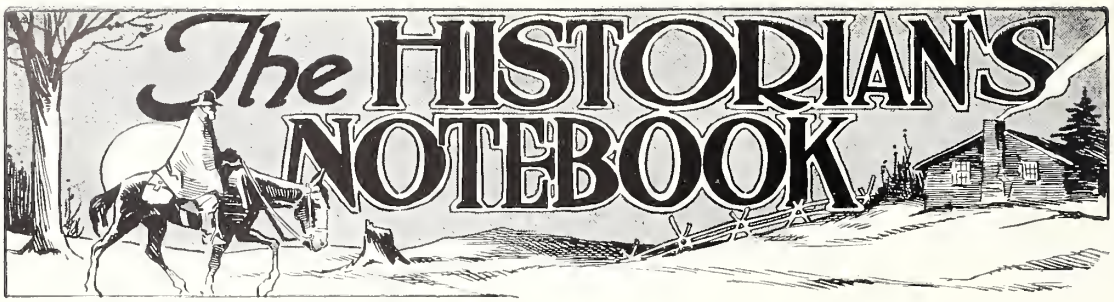
As a byproduct of the writing of the history of the Society [The Medical Society of the State of New York] for publication at the time of the Sesquicentennial, it became evident that much historical research and investigation at the county or grass roots level remains to be done. Published information, although voluminous, as perusal of the Annotated Bibliography in the February 1 issue shows, is yet incomplete for many of the upstate areas and in places downstate.

It is suggested that much progress could be made if county societies were to appoint a historian in those areas where no such action has been already taken. More and more county societies are considering the publication of bulletins; many already have them. Medical historical material of the county area could well be incorporated in those publications. Admittedly a great deal of digging among the local archives would be the lot of such county medical historians, but the results would be worth while.

More and more county societies are founding academies of medicine. The nucleus around which such organizations are constructed is the library. Here the society's historian would have a great usefulness. In most county areas there are probably quantities of textbooks, diaries, records, books of account, pictures, old diplomas, licenses stored in attics and cellars; many local historical societies may have old newspapers, maps, old surgical instruments, and the like to throw light on the development of the area and the lives of its past residents.

The history of medicine in the State is something of which the profession may well be proud. It is integral with the lives of the people who have made it. Let us hope that more and more of the as yet unrecorded gaps may be filled in.—EDITORIAL, *New York State J. Med.*, 57:712, February 15, 1957.

Medicine in Chicago 1850 to 1950, by Thomas Neville Bonner. ($5.00. *American History Research Center, 816 State St., Madison, Wisconsin.)* This book is presented as a chapter in the social and scientific development of an American city. Chicago has been transformed in this hundred years from a disease ridden swamp settlement into one of the leading medical centers of the world. In describing this growth and development Prof. Bonner, associate professor of History and chairman of the Department of Social Sciences at the University of Omaha has done a distinct service to American medical history. The book has one very great merit in that it portrays medical history as part and parcel of the social fabric. Too many of us think of medicine as not being woven into the social order. The result is an account with great insight done in the spirit of wholesome criticism and told with skill.



One Hundred Years of Progress of The Columbus State School

WENDELL A. BUTCHER, M.D., and MARY KNOCHE, B. A.

PART I

THE Columbus State School was established by an Act of Legislature, April 17, 1857, after approximately 13 years of effort. It was not until Dr. Wilbur, Superintendent of the New York Asylum for Feeble-minded, appeared before the assembly with two of his pupils, that sufficient interest was aroused to secure the passage of the bill, making Ohio the fourth state to recognize its responsibility for caring for its mentally handicapped children.

The preamble to this Act reads as follows:

"WHEREAS, The State has recognized the education of its youth as a duty incumbent upon the State, and has provided for those who are susceptible of improvement in common schools, modes of instruction adapted to their wants and capabilities; and, whereas, it appears by the report of the Secretary of State that there are a large number of idiotic youth resident within its borders, who are incapable of improvement in ordinary public or private schools, who are a burden to their friends and to community, objects of commiseration, degraded and helpless; and, whereas, experience has satisfactorily demonstrated, that under the system of instruction adopted in schools for idiots in other States and in Europe, that these youths may be elevated, their habits corrected, and their health and morals greatly improved, and they be enabled to obtain their own support; now, therefore, in the discharge of the duty of the State, to educate its weak and helpless children, as well as the gifted and strong, and to elevate a hitherto neglected class; *Be it enacted*," etc., etc.

Governor Salmon P. Chase appointed three trustees and within 10 days they had appointed Dr. R. J. Patterson, superintendent of the institution. The trustees and superintendent visited the asylums for imbeciles in the states of Massachusetts and New York and from the latter obtained two experienced teachers.

1857 - 1867

A house on Friend Street, now East Main, was leased and on August 3, 1857, the first pupils were received. The minimum number to be admitted was nine, one from each judicial district, and these were to be supported by the state. The name applied to the school at that time was "The Ohio Asylum for the Education of Idiotic and Imbecilic Youth." The pupils were to be no younger than 6 years nor older than 15. Paying pupils were admitted at the discretion of the trustees and the superintendent. Parents or guardian were required to give bond for the support of the child and were to remove it at the request of the superintendent. All pupils were given a vacation during the months of July and August and parents were requested to take them from the school at that time.

By the following year 30 pupils had been enrolled and, since there were an estimated 2,000 such youths in the state, the need for a larger, permanent, farm-like site was felt necessary. An appeal was made, through the Public Press, for donations of land and money, but all that was received was the estate of Mr. Charles Chapman valued at approximately $3,000.

It was not until March 18, 1864, that a bill was passed appropriating $25,000 for the purchase of land and construction of buildings. The present site was purchased (at a much higher sum) and foundation was laid for the new building in 1865.

In a paper presented by Dr. G. A. Doren, who became superintendent, in 1861, he states that "from 1857 to 1864, when the land on which the

The Author

● Dr. Butcher, Columbus, is superintendent of The Columbus State School.

● Miss Knoche, Columbus, is librarian at the school.

central institution is located, was purchased and occupied, the history of the institution was literally a fight against discontinuance (which meant total abolition) by the Legislature, on the one hand, and, on the other, a struggle for enlightment and education of the people outside of the Legislature, as the urgent necessity of an institution for their own benefit, on sociological and economic grounds alone, as well as for the individual betterment and benefit of the feeble-minded, as a class, on grounds of humanity." (A bill was presented in the Senate, in 1862, "to suspend, until otherwise provided by law, the operation" of the act of 1857 under which the institution was created.)

1867-1877

The new building (it was said to be, "Without equal on this planet") was occupied, unfinished, July 1868, by 105 pupils. The capacity was 300 and by the end of the year it was completely filled.

Construction of buildings continued—such as a heating plant, laundry, workshop, coal house and hospital. The major project was the water supply and sewage disposal, and the Scioto River was the solution for both at a cost of $56,000.

By 1875, the school was caring for 376 pupils and the chief complaint was there was "no place to care for adult patients who are past the age of 15 and no longer trainable." It was not, however, until April 22, 1898, that an act, "to provide custodial care for the feeble-minded," provided means for the purchase of additional land.

It was during this period that the name of the school was changed to the "Ohio Institution for the Feeble-minded Youth."

1877-1887

Additional buildings had from time to time been erected and others were in the process of construction, such as: two new wings to the main buildings, schoolrooms above the kitchens, barns, etc. Much of the labor in this construction had been performed by the adult patients.

The grounds were beautified and 30 Shetland ponies were purchased for the amusement of the children.

The population had increased to 614, with 26 teachers, and an orchestra had been organized for both training and entertainment.

November 1881, a great tragedy struck. The central building, along with valuable records and tabulated results of more than 20 years' observation, were destroyed by fire. Reconstruction was commenced immediately and included improvements for the prevention of fire, such as an alarm system, fire escapes, fire doors, et cetera.

Very few of the patients were removed but were crowded into the remaining buildings.

At this time it was felt that the manner of letting contracts should be revised to accelerate construction.

Again, no place to care for the adult patient appeared.

1887-1897

During the fourth decade the stresses were on: More buildings due to the tremendous increase in population; facilities for the care of both male and female adult custodial patients; and buildings to house the epileptics to extend the effectiveness of the institutional services. The latter was met through the establishment of the Gallipolis State Institute in 1893, but nothing was done concerning the others until a later date.

The buildings constructed for the purpose of training the younger children had to be used to house the increased admissions.

During 1888-1890, two buildings were erected for dining rooms, shops and kitchens.

January 4, 1895, the second tragedy from fire struck. The south wing of the main building, housing boys, was two-thirds destroyed but was rebuilt and occupied by May 6th of that year. This occurrence brought about the stress for conversion from gas to electric lighting.

1897-1907

This period marks the beginning of the admission and care of the adult custodial persons. By an Act of April 22, 1898, a tract of land (1068.35 acres) was purchased the following year, at a cost of less than $70,000. It was 14 miles southwest of Columbus and is now known as the Orient State Institute. The farm has since been enlarged.

In 1901, construction of buildings for custodial cases was started for boys at the farm colony and for girls (Lawnview, Cloverleaf and Keiser) at the home institution. It was not until the latter part of this period that these buildings were occupied.

Economy is repeatedly mentioned and is demonstrated by the fact that much of the labor, including the making of bricks, was performed by the adult patients.

In 1904, for the first time, provision was made for the admittance of adult patients and the form of admission was to be legal commitment the same as the insane.*

A telephone exchange was installed at the home institution and at this time conversion of buildings from the purpose for which they were constructed to other purposes was made.

During this period the institution was visited by the British Royal Commission which rated it "above standard."

Dr. Doren died in 1905 and was replaced by Dr. E. H. Rorick.

(To Be Concluded in July Issue)

*"Not to be received were epileptics, insane, vicious, helplessly paralyzed, hopelessly crippled or deformed, the blind, the senile, and dements from causes occurring after puberty." Exceptions were to be considered by the trustees.

Proceedings of The Council . . .

Final Plans for Annual Meeting Approved; Action Taken on Several Legislative Proposals; Committee Reports Made; Programs Discussed

A REGULAR meeting of The Council was held in the Columbus office on Saturday, April 27, 1957. All members were present except Dr. Geo. J. Hamwi, Columbus, Treasurer. Others attending were Mr. Wayne E. Stichter, Toledo, legal counsel; Dr. C. C. Sherburne, Columbus, AMA delegate; and Messrs. Nelson, Saville, Page, Moore and Edgar.

Minutes of the last meeting of The Council held on February 23, 1957, were approved by official action.

MEMBERSHIP DATA

The Executive Secretary presented membership statistics as follows: OSMA members as of April 26, 1957, 8,417, of which 7,424 have affiliated with the AMA.

The official audit of the books of the Ohio State Medical Association and *The Ohio State Medical Journal* for the calendar year, 1956, made by Keller, Kirschner, Martin & Clinger, certified public accountants, Columbus, was discussed and by official action accepted and approved.

There was a discussion of final arrangements for the 1957 Annual Meeting in Columbus, May 14, 15 and 16.

CONSTITUTION AND BY-LAWS

The Council again considered amendments to the Constitution and By-Laws of the Columbus Academy of Medicine, which had been adopted by the Academy and submitted to The Council for approval. A committee representing the Columbus Academy of Medicine was present, consisting of Dr. Phillip T. Knies, Dr. Perry R. Ayres and Dr. L. C. Roettig. Dr. Artman, Councilor of the Tenth District, reported on a conference held with this committee which also was attended by Mr. Stichter, Mr. Nelson, and Mr. Webb, executive secretary of the Columbus Academy of Medicine. Dr. Artman presented recommendations from the conference regarding certain sections of the proposed by-laws of the Academy which had not been approved by The Council, pending further study. By official action, The Council approved, in principle, the recommendations, and requested that the revised document with such recommendations included be acted on by the Academy; and after approval by the Academy, be resubmitted to The Council for final official approval.

An amendment adopted by the Summit County Medical Society on April 2, 1957, increasing the dues for active members of that society to $75.00, was officially approved.

LEGISLATION

Mr. Saville presented to The Council a detailed report on the activities of the Ohio General Assembly, including an analysis of the status of the bills in which the Association is taking a particular interest.

A number of bills on which a policy had not been established were reviewed. By official action The Council approved, in principle, two bills relating to a driver's license for persons afflicted with epilepsy, S. B. 205 and H. B. 569. Approval also was given to H. B. 118 regarding the issuance of marriage licenses to epileptics. By official action The Council voted not to approve H. B. 436, which would allow the signature of only one physician instead of two physicians on an application to have a person admitted to a state hospital for the mentally ill.

The Council voted to actively oppose H. B. 866, to permit mechanotherapists to use anesthetics; H. B. 912, to require local health departments to make polio immunizations available to all persons 19 or under without cost; and S. B. 287, to prohibit any hospital receiving public funds from refusing staff privileges to any licensed physician.

A communication from the Toledo Academy of Medicine regarding H. B. 436 was referred to Dr. Orr, Councilor of the Fourth District, for discussion with officials of the Academy. Two additional questions in the Toledo communication, one on a legal matter involving commitment of a patient to a state hospital and the other with regard to the forms used in admitting patients to a state hospital, were referred to the OSMA Committee on Mental Hygiene for consideration.

Certain resolutions which had been sent to the Columbus office and which will be presented to the House of Delegates at the Annual Meeting were considered briefly by The Council.

COMMITTEE REPORTS

A report from the Committee on Eye Care was reviewed and officially approved.

The Council, also by official action, approved a report from the Committee on Relationship between the Medical Profession and Health Organizations.

RHEUMATIC FEVER PROGRAM

Correspondence sent to local health departments by the State Department of Health, regarding a rheumatic fever program, was dis-

cussed by The Council. It was felt that this matter should be discussed with officials of the State Department of Health. The question was referred to the Committee on Public Relations and Economics for that purpose and report back to The Council.

WORKMEN'S COMPENSATION

A letter from a member regarding the fees allowed by the Bureau of Workmen's Compensation for anesthesia services was referred to the Committee on Industrial Health and Workmen's Compensation.

MEDICARE PROGRAM

During a discussion of the Medicare Program letters commending The Council of the Ohio State Medical Association for the policy adopted on this program from the Columbus Academy of Medicine and the Ohio Society of Anesthesiologists were read and ordered filed.

A request from the Washington Office of Medicare for recommendations for changes in Form 1863 was considered. By official action, the Executive Secretary was instructed to write General Robinson as follows:

"Your communication of April 15 asking for recommendations as to changes in Medicare Form DA 1863 was discussed by The Council of the Ohio State Medical Association on April 27. The Council authorized the presentation to you of the following recommendation:

"Inasmuch as the Ohio State Medical Association believes the Medicare Program should be an indemnity type program, it recommends the modification of Item 29 of DA Form 1863 in such a way that the attending physician would not be required to certify that he will consider the maximum allowance by the Government as full payment for his services."

ETHICAL QUESTION

The Council was advised by the Executive Secretary that a question had been raised regarding the accuracy of a statement of policy adopted by it on February 23, 1957, reading as follows:

"It would be unethical and unlawful for an industrial physician, or an employer, to report to the State Bureau of Workmen's Compensation the name of a handicapped employee, as defined in Section 4123.343 of the Revised Code of Ohio, without specific consent of such employee to the filing of the report or without having on file a waiver of privilege signed by such employee at the time he submitted to pre-employment physical examination."

Specifically, the objection filed with the Association questioned the accuracy of the statement that it would be "Unlawful for an industrial physician or an employer" to report to the bureau.

During the discussion, The Council expressed the opinion that the statement of policy on this question should apply solely to the matter of professional ethics.

After adopting a motion to reconsider the vote by which the original statement of policy was approved, The Council by official vote adopted a substitute statement of policy, reading as follows:

"It would be unethical for a physician to report to the Bureau of Workmen's Compensation the name of a handicapped employee, as defined in Section 4123.343 of the Revised Code of Ohio, without specific consent of such employee to the filing of the report or without having on file a waiver of privilege signed by such employee at the time he submitted to pre-employment physical examination."

MISCELLANEOUS

Dr. Meiling gave a detailed report on the present confused status of the doctors' draft situation.

Several communications from insurance agencies asking the Association to enter certain group insurance programs, were read and discussed. By official action, The Council voted that the Association would not enter into any group insurance program at this time.

Following reports by the Councilors on activities in their districts, The Council adjourned to meet on Monday noon, May 13, at the Neil House on the day preceding the opening of the 1957 Annual Meeting.

Attest: CHARLES S. NELSON,
Executive Secretary.

OSU College of Medicine Honors Four Alumni at Reunion

The College of Medicine at Ohio State University honored four graduates at the Fourth Annual Medical Alumni Reunion on April 27 with Alumni Achievement Awards. They are: Dr. Philip J. Reel, Columbus, Class of 1915, clinical professor of obstetrics and gynecology at Ohio State; Colonel Byron L. Steger, Class of 1933, chief of education and training in the office of the Army Surgeon General, Washington, D. C.; Dr. Paul I. Hoxworth, Class of 1934, Cincinnati, associate professor of surgery, University of Cincinnati; and Lt. Colonel Frank B. Rogers, Class of 1942, director of the National Library of Medicine, U. S. Public Health Service, Washington, D. C.

American Public Health Association Will Meet in Cleveland in Fall

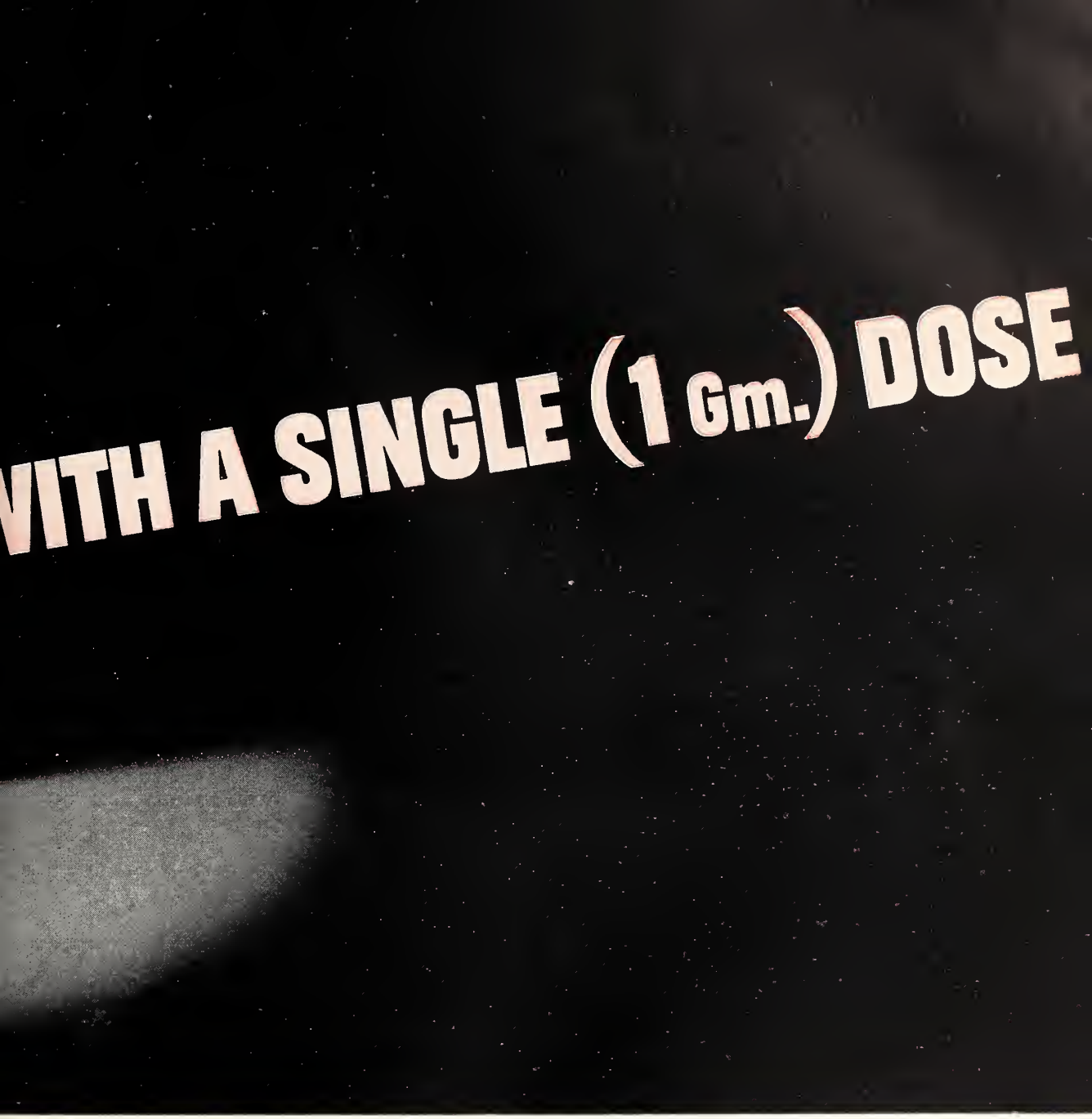
The American Public Health Association will hold its 85th annual meeting in Cleveland, November 11-15. More than 40 related organizations will hold simultaneous meetings, according to Dr. Reginald M. Atwater, executive director of the association with headquarters at 1790 Broadway, New York.

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. Boger, W. P.; Strickland, C. S.; and Gylfe, J. M.: ntibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

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OMI Reports Progress . . .

More Than 110,000 New Members Covered by Ohio Medical Indemnity During the Year; Election of Officers and Directors Is Announced

OHIO MEDICAL INDEMNITY reported continuing gains in the number of persons covered by its prepayment medical and surgical policies at its annual meeting in Columbus April 17. With more than 2,161,000 members in Ohio, OMI is processing about 1,250 claims per working day.

Following are excerpts from the report presented by Mr. Charles H. Coghlan, executive vice-president, for the year:

The year of 1956 was important when examined in the light of results. This year, the eleventh of Ohio Medical, was not a "typical" year—it was different in many respects.

Effective April 1, 1956, Ohio Medical discontinued the sale to new groups of the Surgical-only Contracts, In-hospital Medical Riders and Anesthesia Riders. These were replaced with two Package Plans—the Standard and the Preferred — incorporating the benefits previously available by riders.

NEW BUSINESS

The net growth in new business for the year was 44,411 contracts covering 110,628 members. The breakdown by type of contract was as follows: Standard, 8,146; Preferred, 31,380; Non-Group, 2,841; Special $250 Surgical, 2,044; Total, 44,411.

Following are comparative coverage figures: Total contracts in force, December 31, 1956, 871,283; total members covered, 2,161,117; total Blue Cross Contracts in force, 1,235,390; percentage Blue Cross Contracts in Ohio Medical, 70.5 per cent.

In 1955, OMI added 89,295 contracts covering 218,121 members.

The expansion of voluntary health protection in Ohio and elsewhere has reached the point where practically all groups of ten or more employees have some form of coverage—either Blue Shield and Blue Cross or commercial insurance. In addition, many thousands have some plan on an individual "billed at home" basis.

At the start of 1956, OMI had in effect 8,900 Standard Contracts which also carried the Anesthesia Rider and the In-hospital Medical Rider.

The conversion program got under way in the second quarter of the year. Because of Blue Cross rate increases, the timing was geared individually to fit each Blue Cross Plan's administrative problems.

"Billed at home" subscribers were first notified and converted. Simultaneously, groups were notified of the availability of the new package plans.

By December 31, 1956, OMI had converted 337,423 contracts to the Standard Package. The job is 50 per cent accomplished in the Standard Contract. There are, however, many thousands of groups to be converted and some will take considerable time because of labor-management contracts.

The Preferred Contract had an unusual growth. OMI added 31,380 contracts in the Preferred group, but many of these were not the new Preferred Package. A change in the labor-management contract during 1956 at Timken Roller Bearing Company resulted in the union members moving up from the Standard Surgical to the Preferred Surgical without the In-hospital Medical coverage. In other groups, however, 46,000 Preferred Contracts were converted to the new Preferred Package.

With many more contracts providing additional coverage, the volume of claims continued to rise. Total number of claims paid in the year of 1956 was 270,283. On an average working day now OMI is processing about 1,250 claims and paying out about $1½-million each month.

In the eleven years of Ohio Medical, over 1¼-million claims have been paid for a total of $67¼-million.

INCREASED BENEFITS

Again in 1956 Ohio Medical was able to increase benefits to its subscribers at no increase in rates charged. These increases became effective April 1, 1956, and provided better coverage for large medical bills.

The contracts, both Standard and Preferred, were amended to allow higher benefits for multiple surgical and fracture procedures, performed at the same time, resulting from an accident.

The maximum clause of $200 Standard and $300 Preferred Contracts for related surgery performed in a three-month period was again liberalized by removing this clause from the contract. Now full indemnities are paid for related operations performed at different times.

In addition to these increases, some individual indemnities were raised in both contracts, and the complete transfusion of Rh babies was included as a surgical service in order that some payment could be provided for this service.

Anesthesia services were also extended to provide payment when anesthesia was administered by qualified nurse anesthetists and dentists who are not salaried employees of hospitals.

This year was the first full year for radiotherapy benefits, given to all subscribers in 1955.

Total radiotherapy payments amounted to $208,000 in 1956.

COMMITTEE ACTIVITIES

At the Annual Meeting in April, 1956, a number of standing committees were appointed. Two of these committees—the Future and Past Coverage Committee and the Extended Benefits and National Products Committee—have had a number of projects under study.

These include: the extension of the present coverages now provided in Ohio Medical contracts; a study of major medical expense contracts; the possibility of providing benefits for home and office care after the patient's discharge from the hospital; a study of diagnostic x-ray services both in and out of the hospital; the problem of oral surgery performed by dentists, which is not now covered by the contracts; and a similar problem for services rendered by chiropodists.

The year of 1956 saw considerable activity in the field of radiology and pathology, and there is reason to believe that 1957 will produce additional action. This issue revolves around the relationship of the hospital and these specialties. Ohio Medical has already been advised of the desire of these specialties to have their services removed from hospital bills and hence from Blue Cross contracts, with the thought that these medical services be transferred to the Blue Shield contracts.

FINANCIAL FIGURES

A report to the Board by the Assistant Secretary-Treasurer revealed the following:

Ohio Medical Indemnity now has assets in excess of $15,000,000.00 as shown in the annual report as of December 31, 1956. This represents an increase in assets of $2,766,000.00 for the year 1956, its eleventh year of operation.

Over 270,000 policyholders filed claims during the year 1956. The checks issued totalled $15,081,000.00. During the 11 year history of Ohio Medical, $67,000,000 has been paid to its policyholders.

The anticipated monthly claim payments during the year 1957 will average one and one-half million dollars per month.

DIRECTORS ELECTED

The following directors of OMI were elected or re-elected at the annual meeting on April 17:

New directors elected—Fred D. Learey, Ohio Bell Telephone Company, Columbus; Msgr. Robert A. Maher, director of Catholic Hospitals Catholic Charities, Toledo; Richard Ross, the Ross Laboratories, Columbus; and James Walker, Walker Clothing Store, Columbus.

Directors re-elected—Dr. Robert T. Allison, Jr., Akron; Dr. H. M. Clodfelter, Columbus; Dr. R. Dean Dooley, Dayton; D. A. Endres, Youngstown Hospital Association, North Side Unit, Youngstown; Dr. D. W. English, Lima; Clair E. Fultz, Huntington National Bank, Columbus; Dr. Charles N. Hoyt, Chillicothe; Dr. J. Stewart Mathews, Wyoming; Dr. Carll S. Mundy, Toledo; Dr. George L. Sackett, Cleveland; Dr. L. Howard Schriver, Cincinnati; Dr. C. C. Sherburne, Columbus; Harold W. Slabaugh, Akron; Dr. Robert G. Smith Circleville; David L. Temple, Delco Products, Dayton; Dr. Edmond K. Yantes, Wilmington; and Dr. Starling C. Yinger, Springfield.

OFFICERS ELECTED

The Board elected or re-elected the following officers for 1957-1958: Dr. Sherburne, president, to succeed Dr. Mundy; Dr. Clodfelter, vice-president, to succeed Dr. Sherburne; Charles H. Coghlan, executive vice-president; Charles S. Nelson, secretary-treasurer; Frank W. Van Holte, assistant secretary-treasurer; Wayne E. Stichter, Toledo, legal counsel.

EXECUTIVE COMMITTEE

Dr. Sherburne as president appointed the following Executive Committee: Dr. Clodfelter, chairman; Dr. Allison, Dr. Yinger, Dr. Hoyt, Dr. Sackett, Dr. Yantes, Mr. Fultz, Mr. Slabaugh and Dr. Dooley.

OTHER COMMITTEES

Other committees appointed by the president are the following:

Future and Past Coverage Committee — Dr. Yantes, chairman; Dr. Dooley, co-chairman; Mr. Walker and Drs. Allison, English and Smith.

Extended Benefits and National Enrollment Committee—Dr. Hoyt, chairman; Dr. Yinger, co-chairman; Drs. Mundy, Schriver and Clodfelter, Monsignor Maher and Mr. Temple.

Investment Committee—Mr. Fultz, chairman; Dr. Clodfelter, co-chairman; Dr. Sherburne and Mr. Van Holte.

Blue Cross and Public Relations Committee—Mr. Slabaugh, chairman; Dr. Sackett, co-chairman; Mr. Endres, Dr. Mathews; Mr. Ross and Mr. Learey.

Pension Committee—Dr. Clodfelter, chairman; Mr. Fultz and Mr. Slabaugh.

Scientific Sessions of American Heart Association To Honor William Harvey

The 30th Scientific Sessions of the American Heart Association, to be held in Chicago's Hotel Sherman, Friday, October 25, through Monday, October 28, will commemorate the 300th anniversary of the death of William Harvey, English scientist who discovered the circulation of the blood.

Deadline for abstracts of papers to be presented at the sessions is June 15.

To honor William Harvey, a special exhibit and a film showing his work are planned. There will also be a brief dedication ceremony on Saturday morning, when the regular Scientific Sessions get underway. The American Heart Association office is at 44 East 23rd Street, New York 10, N. Y.

Rural Health . . .

OSMA Activities Include Orientation in Rural Practice for Medical Students; Practice Preceptorships; Work with the 4-H Club Programs

PRECEPTORSHIPS, lectures to medical students, 4-H Club personal health records, condensed physical examination forms for 4-H Club health competitions—these represent activities of the Committee on Rural Health, culminating in June when 15 medical juniors from the University of Cincinnati College of Medicine will spend two weeks with rural general practitioners. By having them observe rural medicine as it is actually practiced, the committee hopes to interest students in selecting rural places to practice, before they begin their senior year of medicine. This is the first year for the program.

Also aimed at interesting more young physicians-to-be to consider a rural location are lectures to medical seniors at Ohio State University, the University of Cincinnati and Western Reserve University juniors as well as seniors. This year marked the sixth annual lecture series at Ohio State, the third at Cincinnati and the first year at Western Reserve.

Topics covered include types of practice encountered, selecting the place to practice, ethics, hospital affiliations and emergencies and medical economics. In each series, the lectures were concluded with a dinner for the students and their wives or girl friends. Dinner speakers were President Richard L. Meiling, who spoke on "The Physician and His Medical Society," and Dr. E. K. Yantes, Wilmington, chairman of the sponsoring committee, who spoke on "The Physician and His Community."

Lecturers included Drs. J. Martin Byers, Greenfield; George A. Woodhouse, Pleasant Hill; Richard R. Buchanan, Wilmington; Victor R. Frederick, Urbana; Robert E. Reiheld, Orrville, and John H. Budd, Cleveland. Discussants included Dr. George N. Spears, Ironton; Dr. Charles H. McMullen, Loudonville, and Dr. John P. Miller, Orrville.

Cooperating in the series were the schools of medicine and the local chapters of the Student American Medical Association. To emphasize the Ohio State Medical Association's interest in medical students and the Student AMA, Dr. Meiling presented checks for $75 to the Ohio State and Cincinnati chapters, and Dr. George W. Petznick, Shaker Heights, Fifth District Councilor, presented a check in a like amount to the WRU chapter, the checks being from OSMA to help defray expenses for the chapter's delegates at the SAMA national meeting in Philadelphia in May.

4-H CLUBS

In another activity of the Committee on Rural Health, a personal health record for 4-H boys and girls was written and edited by the committee, with 50,000 copies published by OSMA for 4-H club members to use as a part of their personal health projects. The record has gained high praise from both state and national 4-H circles.

The record, which the 4-H'er can use as a simple but complete method of recording his personal health statistics until he reaches adult age, was designed as the answer to the need for an efficient, thorough method for recording such information.

In the same vein, the committee prepared for printing by the state 4-H headquarters a new 4-H physical examination form that would answer the need for an abbreviated but thorough form. The committee held the form to two sides of an

(Continued on Page 688)





Left picture taken following Cincinnati lecture shows President Meiling (center) conferring with Dr. Charles A. Sebastian (left), past-president of the Cincinnati Academy and Dr. Frank H. Mayfield, First District Councilor. Right is a scene during the Cincinnati lecture dinner, attended by students and their wives. Seated at the extreme right at the speakers' table is Robert Rakel, president of the Cincinnati Chapter, Student American Medical Association, and since then elected national president of the Student AMA. The dinner meeting concluded the series of weekly lectures.

Participants in Lectures to Medical Students



Dr. George A. Woodhouse, Pleasant Hill, member of the AMA Judicial Council, delivering the lecture on ethics at Ohio State.



Shown here is the Ohio State College of Medicine lecture dinner for students and guests, held in the east ballroom of Ohio Union. The lecture series, initiated at Ohio State, now is conducted annually at all three medical schools in Ohio.



Be active in community life, Dr. E. K. Yantes, chairman, Committee on Rural Health, tells Cincinnati students.



Western Reserve lectures: Center, left to right, Dr. George W. Petznick, Shaker Heights, Fifth District Councilor; Dr. H. T. Pease, Wadsworth, Eleventh District Councilor; and Dr. John P. Miller, Orrville, lecture discussant. Western Reserve officials have indicated approval of the lectures as an annual series.



Ethics: Dr. John H. Budd, Cleveland, delivering the Western Reserve lecture on medical ethics.



Dr. Charles H. McMullen, Loudonville, Committee on School Health, discusses emergencies at Reserve.



Dr. V. R. Frederick, Urbana, member, Committee on Rural Health, tells Ohio State students, "You can get a lot of enjoyment out of medical practice if you use the right approach."



Dr. G. Newton Spears, Ironton, member, Committee on Rural Health, discusses medical emergencies for benefit of Cincinnati students.



Dr. Richard R. Buchanan, Wilmington, member, Committee on Rural Health, speaks on hospital affiliations at Cincinnati.



Dr. Howard D. Fabing, president, Cincinnati Academy of Medicine, offers remarks at the Cincinnati lecture dinner for students and wives.

At WRU, Cincinnati and Ohio State



"It's in the bag," Dr. Robert E. Reiheld, Orrville, member, Committee on Rural Health, tells Western Reserve students.



Dr. J. Martin Byers, Greenfield, member of Committee on Rural Health, talks on types of practice encountered at University of Cincinnati.



Be active in your medical organizations, President Meiling tells Ohio State medical students at the 1957 lecture dinner.

8½ by 11-inch sheet, and still left ample space for comments by the examining physician. This form also has drawn many favorable comments.

Other projects of the committee include a year's subscription to *Today's Health* for each county boy and girl health competition winner in Ohio, assisting with physical examinations at the statewide 4-H health competition and sponsoring the winner of the boys' statewide health contest at the National 4-H Congress in Chicago.

Assisting the committee in these projects were Hart F. Page and Charles W. Edgar, Jr., of the OSMA state headquarters staff.

Fort Steuben Academy

The Fort Steuben Academy of Medicine had as guest speaker for the May 14 dinner meeting Dr. Richard B. Cattell, director of the Lahey Clinic, and surgeon-in-chief of the New England Baptist Hospital, Boston. Local co-speaker was Dr. Albert Winston, of the surgical staff of the Ohio Valley Hospital in Steubenville. Subject of discussion was "Recent Changes in the Treatment of Carcinoma of the Large Bowel."

Postgraduate Gastroenterology

The American College of Gastroenterology announces that its Annual Course in Postgraduate Gastroenterology will be given at The Somerset in Boston, Mass., on October 24, 25, 26, 1957. Additional information may be obtained from the college at 33 West 60th Street, New York 23, New York.

Recent Opinion of the Attorney General

Following is the syllabus of an opinion given recently by Attorney General William Saxbe:

1. When a bond issue or tax levy approved under the terms of Section 339.01, Revised Code, provides funds for constructing an addition to an already existing county hospital and to build a new building, such funds are, under Section 339.04, Revised Code, credited to the county hospital building fund to be expended on the order of the board of county hospital trustees.

2. Funds in the county hospital building fund are, under Section 339.04, Revised Code, expended on the order of the board of county hospital trustees, certified by the chairman and secretary of the board.

3. Projects of construction by the board of trustees of a county hospital can be undertaken only by the use of the proceeds of a bond issue or tax levy therefor submitted and approved in accordance with Section 339.01, Revised Code; and the use of a county hospital operating fund for such purpose is not authorized by law.—Opinion No. 330.

Five Veterans Administration hospitals have begun a study to learn the cause and nature of sarcoidosis. Physicians at each of the hospitals have volunteered to study the disease clinically but with equal emphasis on factors such as environment, occupation, eating habits and self-medication.

Latest on Medicare . . .

Increases Made in Allowances for Multiple Procedures; Additional Information on Ohio Program Based on Official Communications

HERE is additional information on the Medicare Program as it relates to Ohio, particularly, based on data and correspondence from Mutual of Omaha, Omaha, Neb., the fiscal administrator for Ohio on the medical aspects of the program, and on general bulletins from the Medicare Office in Washington.

The U. S. Government has amended the details of the Ohio Medicare Program so that additional payments may be made to physicians when multiple procedures are involved. The amendment involves deletion of the section "General Information" on page 27 of the gray booklet "Physicians' Fees and Procedure Guide" and substitution of the following:

ALLOWANCES FOR MULTIPLE PROCEDURES

Any allowance in this schedule for a surgical procedure includes the customary pre-hospitalization care rendered by the surgeon for the same condition for which the surgical procedure is performed, but does not include any pre-hospitalization care rendered by an attending physician other than the surgeon. Any allowance for a surgical procedure also includes the customary after-care incident to such surgical procedure.

Two physicians may not be paid an allowance for attendance on the same case at the same time except where it is warranted by the necessity of supplementary skills, provided, however, when one physician performs any service for which there is an established flat allowance and another physician renders the aftercare, or any portion of it, such allowance will be apportioned in relation to the responsibility and work done, but the total shall not exceed the flat allowance. When a case is referred to another physician for aftercare, it is the responsibility of the referring physician to recite such fact on the claim form to be filed with the Fiscal Administrator.

UNUSUAL TREATMENTS

In any case requiring unusual treatment not contemplated under ordinary circumstances, the physician shall receive such additional allowance as may be determined by the procedure prescribed in the Joint Directive and in the contract. A detailed report of such treatment shall be submitted by the physician to the Fiscal Administrator.

In multiple surgical procedures performed by the same surgeon through the same incision, an allowance will be made only for the major procedure except in unusual cases.

In multiple surgical procedures performed by the same surgeon in separate operative fields or through separate incisions, the allowance shall be the allowance designated for the major procedure, plus fifty (50) per cent of the allowance designated for each of the other procedures unless otherwise specified in this schedule.

Bilateral procedures in separate operative fields will be allowed an additional fifty (50) per cent unless otherwise specified in this schedule.

In any case involving more than one dislocation, the allowance shall be the allowance designated for the major dislocation, plus fifty (50) per cent of the allowance designated for each of the other dislocations.

In any case where more than one bone is fractured, the allowance shall be the allowance designated for the major fracture, plus fifty (50) per cent of the allowance designated for each of the other fractures unless otherwise specified in this schedule.

In any case involving both dislocations and fractures, the allowance shall be the allowance designated for the major procedure plus 50 per cent of the allowance designated for each of the other procedures unless otherwise specified in this schedule.

Procedures not specifically listed will be given an allowance comparable to the listed procedure of closest similarity, upon written report.

An allowance for procedures designated "Report" in this schedule will be determined, after individual consideration of the particular facts of the case, by the Executive Agent on recommendation of the medical advisory committee in accordance with the agreement with the Government's Contracting Officer.

FEE FOR ASSISTANT

A physician assisting in a major surgical procedure shall be paid an allowance equal to twenty (20) per cent of the allowance payable to the surgeon but not less than $10.00. It is the

Any Changes To Suggest?

Physicians who may have suggestions for changes in Medicare Form 1863 to make it more workable and clearer should send their suggestions to the Office of Dependents Medical Care Program, Office of Surgeon General, Department of the Army, Washington 25, D. C. The form is going to be revised in the near future and that office is soliciting recommended changes.

responsibility of the surgeon to report the name of the assistant to the Fiscal Administrator. However, no allowances are payable to physicians in training status.

Allowances for X-ray, anesthesia and laboratory procedures are listed elsewhere in this schedule.

CORRECTION IN MANUAL

A correction in the Ohio Manual has been authorized. It relates to Page 17, paragraph 5 under "Emergency Care." In the printed paragraph no mention is made of a hospital. The paragraph should read "Care is authorized **in a hospital** in acute emergencies, etc."

Mutual of Omaha has advised that anesthesiologists do not always check if the patient was hospitalized. This is because of the way the form reads. Forms have to be returned when this is overlooked.

Also, Mutual of Omaha has observed that physicians handling obstetrical cases should make sure to indicate on the form the date of delivery so antepartum care can be properly analyzed. This is not required on the blank at present but will be corrected in future revisions of the form.

THE PHYSICIAN'S CHOICE

In a communication to fiscal administrators on April 26, the Washington Office of Medicare pointed out that either A or B of the second set of A's and B's in Item 29 of Form 1863 must be checked by the physician before payment can be made because "the Dependents Medical Care Program is one of full service coverage and the item must be checked to indicate that the patient is not additionally charged by the physician." Physicians handling patients under the Medicare Program should understand this. The decision rests with the physician as to whether he will accept a patient under the program and accept the government's allowances as payment in full or whether to accept the patient as a private patient—not under the program—and make his usual charge for services, which may be different from the government allowance.

Payments To Ohio Doctors

Data secured from Mutual of Omaha show the following Ohio claims paid and the amounts paid to physicians for January, February, March and April to the 15th: January, 44, $11,754; February, 584, $39,625; March, 816, $59,357; April (to 15th), 572, $38,359.

About three-quarters of all deaths in the Army are due to injury, an Army release reported. Roughly one half of injuries are accounted for by automobile accidents, most of which occur during off duty hours.

Narcotics Registration Must Be Renewed by July 1

On or before July 1, every physician registered under the Harrison Narcotic Act, must (unless he is in military service) re-register with the Director of Internal Revenue of the district in which he maintains an office and pay the Federal Narcotic Tax of $1. Initial application may be made at any time, but existing permits must be renewed on or before July 1, annually.

Revised Form 678 has been mailed by the Narcotics Division to physicians on record. But the physician is responsible for re-registering whether or not he receives a form. A penalty is incurred by those who fail to re-register before deadline. Gross violations of the Narcotic Act are punishable by heavy fines and imprisonment.

Physicians who administer, dispense or prescribe cannabis must obtain a special permit under the Marihuana Tax Act and pay an additional tax of $1.

UC Physicians Participate in National Pathology Meet

Several members of the Department of Pathology, University of Cincinnati College of Medicine, prepared papers for or participated in annual meetings of the International Academy of Pathology and the American Association of Pathologists and Bacteriologists which met in Washington April 8-13. They are: Dr. Edward A. Gall, head of the Department; Dr. Jan Schwarz, Dr. Benjamin H. Landing, Dr. G. L. Baum, Dr. C. J. Koa, Dr. Joseph H. Smith, Dr. Herbert Braunstein, Dr. Boris Gueft; also Dr. Bernard Black-Schaffer, Dr. Uriel Garcia and Dr. David G. Freiman, formerly with the Department.

Occupational Skin Problems, Subject of Course at UC

The Institute of Industrial Health of the University of Cincinnati has announced that the third biennial course of instruction in "Occupational Skin Problems" will be given during the week of October 28 - November 1. It will be presented by the Department of Preventive Medicine and Industrial Health, University of Cincinnati, in collaboration with the Occupational Health Program of the United States Public Health Service, and the Department of Dermatology of the University of Cincinnati. The objective of this course is to give physicians a greater understanding of cutaneous problems of occupational origin.

Results of Election at Annual Meeting in Columbus: Detailed Reports To Appear in July Issue

Limited time made it impossible to include in this issue of *The Journal* the many reports that come from the 1957 Annual Meeting of the Ohio State Medical Association held in Columbus May 14-16. These reports, with biographical sketches of the newly elected officers, proceedings of the House of Delegates and other data will appear in the July issue.

So important, however, is the election of officers, Councilors, and Delegates to the AMA that this informaion is reported.

Dr. Robert S. Martin, Zanesville, was installed as President to succeed Dr. Richard L. Meiling, Columbus, who remains on The Council for another year as the immediate Past-President.

Dr. George A. Woodhouse, Pleasant Hill, was named President-Elect and will be installed as President at the 1958 Annual Meeting in Cincinnati. Dr. Woodhouse has served as Councilor for the Second District.

Dr. R. Dean Dooley, Dayton, was elected Second District Councilor to succeed Dr. Woodhouse. Councilors re-elected for additional two-year terms are: Dr. Paul F. Orr, Perrysburg, Fourth District; Dr. C. A. Gustafson, Youngstown, Sixth District; Dr. William D. Monger, Lancaster, Eighth District, and Dr. Edwin H. Artman, Chillicothe, Tenth District. Hold-over Councilors are: Dr. Frank H. Mayfield, Cincinnati, First District; Dr. James R. Jarvis, Van Wert, Third District; Dr. George W. Petznick, Cleveland, Fifth District; Dr. Robert E. Hopkins, Coshocton, Seventh District; Dr. Carter L. Pitcher, Portsmouth, Ninth District; and Dr. H. T. Pease, Wadsworth, Eleventh District. Dr. Geo. J. Hamwi, Columbus, is Treasurer.

Elected for two-year terms as delegates and alternates to the American Medical Association, effective January 1, 1958, are the following: Dr. Paul A. Davis, Akron, delegate; Dr. Edmond K. Yantes, Wilmington, alternate; Dr. Carll S. Mundy, Toledo, delegate; Dr. Paul F. Orr, Perrysburg, alternate; Dr. L. Howard Schriver, Cincinnati, delegate; Dr. Charles A. Sebastian, Cincinnati, alternate, to succeed Dr. E. O. Swartz, also of Cincinnati; Dr. C. C. Sherburne, Columbus, delegate; Dr. Richard L. Meiling, Columbus, alternate.

Hold-over delegates and alternates are: Dr. Carl A. Lincke, Carrollton, delegate; Dr. H. M. Platter, Columbus, alternate; Dr. Charles L. Hudson, Cleveland, delegate; Dr. C. E. Hufford, Toledo, alternate; Dr. George A. Woodhouse, Pleasant Hill, delegate; Dr. R. Dean Dooley, Dayton, alternate; Dr. Herbert B. Wright, Cleveland, delegate; Dr. Fred W. Dixon, Cleveland, alternate.

Course in Pulmonary Diseases . . .

Designed for Physicians in General Practice, Program at Ohio State University Is Jointly Sponsored by the OSMA and Other Organizations

FIVE sponsoring organizations have joined forces to offer a postgraduate course in pulmonary diseases especially for general practitioners and approved for credit by the Ohio Academy of General Practice. The course is scheduled at Ohio State University in Columbus on Friday and Saturday, September 27 and 28.

Sponsors are the Ohio State University College of Medicine, the Ohio State Medical Association, Ohio Trudeau Society, American Trudeau Society, and the Ohio Tuberculosis and Health Association.

Reservation for the course, accompanied by a check for $15 should be sent to: Mr. Bernard Lachner, treasurer, c/o Ohio Tuberculosis Hospital, Columbus 10. Registration is limited to 150. Hotel reservations should be made with the hotel of choice. The Neil House and the Deshler-Hilton have reserved a limited number of rooms for those attending, up until September 5. (The football weekend makes this early reservation necessary.)

An additional attraction is the Ohio State-Southern Methodist football game on Saturday afternoon, September 28.

The registration fee includes one ticket for the banquet on Friday evening. Extra tickets at $5 each may be secured for those who wish to bring their wives.

The course has been designed to provide the physician in general practice with current concepts of pulmonary disease, cardiac surgery, and carcinoma with emphasis on practical aspects of diagnosis and treatment.

The program will be held in the Ohio Union Theater, Ohio State University, High Street at 13th Avenue. The banquet will be held in the Hall of Mirrors, Deshler-Hilton Hotel.

OUT-OF-STATE GUEST SPEAKERS

Five out-of-state guest physicians, each an outstanding figure in the field of pulmonary diseases, will participate in the program. Following are biographical sketches of each:

Oscar T. Clagett, M. D., professor of surgery, Mayo Foundation Graduate School, Rochester, Minnesota. Dr. Clagett was graduated from the University of Colorado School of Medicine in 1933. He was certified by the American Board of Surgery and American Board of Thoracic Surgery in 1940, and has been head of the Division of Surgery, Mayo Clinic since 1940.

Arthur M. Olsen, M. D., associate professor of medicine, University of Minnesota, Graduate School of Medicine, Mayo Foundation, Rochester, Minnesota. A. B., Dartmouth College, 1930; M. D., University of Chicago, Rush Medical College, 1946; Fellow in Medicine, Mayo Foundation, 1936-40.

John B. Hickman, M. D., associate professor of medicine, Duke University, Durham, North Carolina 1951 to present. A. B., Harvard U., 1936; M. D., Harvard U. School of Medicine, 1940; Fellow American College of Physicians; Diplomate, American Board of Internal Medicine, member American Society for Clinical Research and American Society for Clinical Investigation.

Oscar A. Sander, M. D., assistant clinical professor of occupational and environmental medicine, Marquette University, School of Medicine, Milwaukee, Wis., 1946 to present. B. A., University of Wisconsin 1924; M. D., University of Pennsylvania, 1927; Mellon Fellow, University of Pittsburgh Medical School, 1928-29; fellowship in pathology, Erdheim Pathological Institute, Vienna, Austria, 1929-30; clinical staff, Wisconsin Anti-Tuberculosis Association 1930-32; Fellow American College of Physicians, American College of Chest Physicians and Industrial Medical Association. Certified American Board of Preventive Medicine; member Industrial Health Council, American Medical Association, chairman, Medical Committee, Industrial Hygiene Foundation of America, Mellon Institute, Pittsburgh, Pa.

William M. Tuttle, M. D., clinical associate professor of surgery, Wayne University College of Medicine, Detroit, Mich.; M. D. from University of Chicago, 1931; Internship and clinical training, University of Chicago; clinical training, Barnes Hospital, St. Louis; appointments, Harper Hospital, Receiving Hospital, Woman's Hospital and Herman Kiefer Hospital all of Detroit; Lt. Col., MC, AUS, during World War II; member American Association for Thoracic Surgery, Western Surgical Association, Central Surgical Association, American Trudeau Society, American Broncho-Esophagological Association, Central Society for Clinical Research, American Surgical Association; diplomate of the American Board of Thoracic Surgery.

Faculty appointments for other participants on the program are in the Ohio State University College of Medicine, unless otherwise specified.

PROGRAM

The program has been announced as follows:

FRIDAY MORNING, SEPTEMBER 27

Chairman: Dr. George O. Kress, clinical assistant professor of medicine.

9:00 - 9:30 a. m.—Registration.

9:30 - 9:45—Welcome and Introduction, Dr.

Charles A. Doan, dean of the OSU College of Medicine.

9:45 - 10:10—**Bronchitis and Emphysema**, Dr. John A. Prior, chief of the Division of Pulmonary Diseases and professor of medicine.

10:10 - 10:30—**Practical Points in Tuberculin Testing and Interpretation; Present Status of BCG Vaccination**, Dr. Robert H. Browning, director of the Ohio Tuberculosis Hospital and professor of medicine.

10:30 - 11:15—**Chemotherapy and Inhalation Therapy in Respiratory Diseases**, Dr. Arthur M. Olsen (Guest Speaker).

Coffee Break.

11:30 a. m. - 12:15 p. m.—**Cor Pulmonale**, Dr. John B. Hickam (Guest Speaker).

12:15 - 1:00—**The Finer Points of Diagnosis in Pulmonary Diseases**, A Panel Discussion:

Moderator—Dr. Robert J. Atwell, assistant professor of medicine and chief of medical services, Ohio Tuberculosis Hospital.

Dr. Benjamin Felson, professor and director, Department of Radiology, University of Cincinnati College of Medicine.

Dr. William M. Tuttle (Guest Speaker).

Dr. John B. Hickam (Guest Speaker).

Dr. A. M. Olsen (Guest Speaker).

Dr. O. A. Sander (Guest Speaker).

1:00 - 2:00 p. m.—Luncheon.

FRIDAY AFTERNOON

Chairman: Dr. Phillip B. Hardymon, Associate professor of surgery.

2:05 - 2:30—**Pulmonary Function Tests for Office and Small Hospital.** Dr. Joseph F. Tomashefski, assistant professor and chief of research at Ohio Tuberculosis Hospital.

2:30 - 3:15—**The Pneumoconioses**, Dr. Sander (Guest Speaker).

3:15 - 3:30—**The Pathology of Intrapulmonary Cavitary Lesions**, Dr. Philip C. Pratt, instructor, Department of Pathology, chief of laboratories, Ohio Tuberculosis Hospital.

3:30 - 3:40—**Pulmonary Biopsy in Diffuse Lesions of the Lung**, Dr. Karl P. Klassen, professor and director of the Division of Thoracic Surgery.

Coffee Break.

4:00 - 4:50—**Diagnostic Radiology of the Chest**, Dr. Benjamin Felson, professor and director of the Department of Radiology, University of Cincinnati College of Medicine.

FRIDAY EVENING

6:15 - 7:00—Cocktails.

7:00 - 8:30—Banquet—Toastmaster: Chauncey D. Leake, Ph. D., assistant dean of the OSU College of Medicine and professor of pharmacology.

8:30—**Carcinoma of the Lung**, Dr. Clagett (Guest Speaker).

SATURDAY, SEPTEMBER 28

Chairman: Dr. Neil C. Andrews, assistant professor of surgery and chief of surgical service, OTH.

9:00 - 9:45—**Solitary Lesions of the Lung**—A Symposium, Dr. Tuttle (Guest Speaker), and Dr. Joseph B. Stocklen, controller of tuberculosis for Cuyahoga County.

9:45 - 10:05—**Present Status and Trends in Tuberculosis; The Ohio "Recalcitrant" Law**, Dr. Ralph E. Dwork, director of the Ohio Department of Health and assistant professor of preventive medicine.

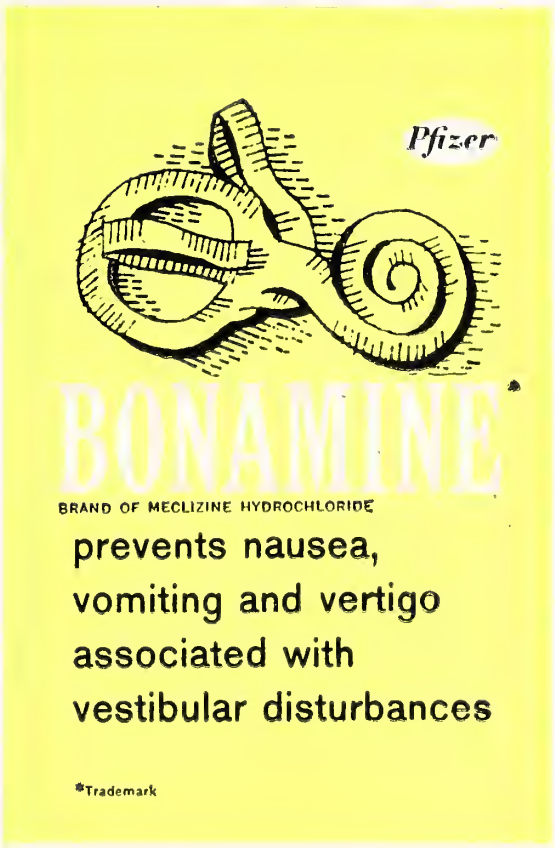
Coffee Break.

10:25 -10:45—**Asthma—Practical Aspects of Therapy**, Dr. John H. Mitchell, clinical professor of medicine (allergy).

10:45 - 11:30—**Presentation: Cases of Unusual Interest**, Staff of the Ohio Tuberculosis Hospital.

2:00 p. m.—Ohio State - Texas Christian Football Game.

One out of every 14 boys and one out of every 17 girls under age 20 are hospitalized in the course of a year. This information was based on a stay of at least one night in a hospital for minor dependents of persons carrying group insurance.—Metropolitan Life.



Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

The new National Library of Medicine will be housed in a building to be constructed on the grounds of the National Institutes of Health, Bethesda, Md., a Washington suburb, it has been decided by the library's board of regents. The 1956 law changing the Armed Forces Medical Library to the National Medical Library directed the surgeon general to select the site "in accordance with directions of the board."

* * *

A special House subcommittee heard two auto accident researchers indorse use of the lap safety belt and state that they felt manufacturers would equip autos with such belts when the public makes it plain that the buyer wants them. One of the witnesses was John O. Moore, director of auto crash injury research, Cornell University College of Medicine. Mr. Moore participated on a crash injury panel at the OSMA Annual Meeting in May.

* * *

Move is under way in Washington to draw up a guide for use in dispensing public information concerning nuclear explosions and their subsequent results, including medical information. Critics of the present, un-coördinated method maintain that the public should have an authoritative reference with which to interpret the welter of scientific terminology.

* * *

Dr. Frederick D. Mott has resigned as director of John L. Lewis' Miners Memorial Hospital Association of United Mine Workers to join Walter Reuther's Community Health Association in Detroit, effective June 30. He will be executive director of the CHA, an indication that the Reuther undertaking will be dynamic, Washington observers believe.

* * *

Newly formed Task Force on Health Manpower has job of surveying medicine, dentistry and nursing as to training, procurement—health manpower from every perspective.

* * *

Federal Civil Defense Administration recently reported that in six-year period ending June 30, 1956, it purchased and stockpiled for national emergency, among other items, $163-million worth of medical supplies and equipment, including 26-million doses of vaccines and antitoxins, 7.8-million burn dressings, 201 emergency hospitals, 500,000 doses of atropine and 1.5-million units of plasma and serum albumin.

Rep. John E. Fogarty (D., R. I.), effective in getting large Federal grants for medical research and considered a Congressional leader in health and medical legislation, has called for (1) expansion of basic research, (2) concurrent expansion of research into specific diseases and disease problems, (3) education of more doctors "because we now have a shortage of general practitioners and research specialists as well," (4) greater cooperation between medicine and industry for technological advances, and (5) maximum utilization of the new Federal law authorizing $30-million annually in grants to build, improve research facilities.

* * *

Internal Revenue Service has ruled that contributions paid by hospitals to religious groups in return for free services performed by members are not wages for tax withholding or gross income purposes.

* * *

Public Health Service plans to inaugurate this summer a new research traineeship program, with every medical and dental school eligible to participate. Also, HEW is asking Congress to let Vocational Rehibalitation office finance full three years of residency for selected physicians interested in rehabilitation and physical medicine.

* * *

National Research Council's Committee on Cancer Diagnosis and Therapy, established in 1951 to examine unorthodox and unusual treatment of cancer, in effect, to investigate cancer quackery, has been disbanded. Committee left "policing" up to state and local medical societies.

* * *

National campaign to unionize laboratory technicians and x-ray technicians, launched in Washington, is reportedly fanning out. Objectives are higher pay and better working conditions. Name of union is Federation of Technical, Medical Personnel, and parent union is Office Employees' International Union (AFL-CIO). Organizers hope to bring in later other allied professions, perhaps nurses.

* * *

As of March 31, 1957, there were 1,717 veterans of World War II and 16,688 veterans of the Korean Conflict undergoing training under the Vocational Rehabilitation program, Veterans Administration reported. An additional 610,377 World War II, and 30,651 Korean Conflict veterans had previously taken training under the program.

FOR POSITIVE DIURESIS

ROLICTON®

Brand of Amisometradine

- oral b.i.d. dosage
- continuous control of edema

The new, highly effective oral diuretic, Rolicton, greatly simplifies the task of maintaining an edema-free state in the patient with congestive heart failure. Rolicton meets the criteria for a dependable diuretic: continuous effectiveness, oral administration and clinical safety.

In extensive clinical studies the diuretic response clearly indicates that a majority of patients can be kept edema-free with Rolicton. In these investigations it was noted that side reactions were uncommon. When they did occur they were usually mild.

In most edematous patients Rolicton may be employed as the sole diuretic agent. When used adjunctively in severe cases, Rolicton is also valuable in eliminating the "peaks and valleys" associated with the parenteral administration of mercurial diuretics.

One tablet of Rolicton b.i.d., after meals, is usually adequate for maintenance therapy after the first day's dosage of four tablets. Some patients respond well to one tablet daily. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.



SEARLE

Jenkins-Keogh Drive Started . . .

AMA Joins With Other National Organizations of Self-Employed To Help Secure Passage of Tax-Free Pension-Retirement Program

FORMATION of the American Thrift Assembly for Ten Million Self-Employed has been evaluated by veteran Washington observers as an expedient move in achieving passage of the Jenkins-Keogh bill to give tax-free pension benefits to non-salaried professional persons, which would include most physicians.

The Jenkins-Keogh bill actually is two identical bills—H. R. 9 introduced by Congressman Thomas A. Jenkins, Ohio, and H. R. 10, introduced by Congressman Eugene J. Keogh, New York.

SUPPORTED BY AMA AND OSMA

The American Medical Association and its constituent state medical associations, including the Ohio State Medical Association, have actively supported proposals of this kind for a number of years.

Although those observers believe enactment of the legislation by the present Congress has favorable odds, it still must be remembered that similar moves in past years never got off the ground.

SHOULD CONTACT CONGRESSMEN

Ohio physicians who are in favor of this legislation should contact their representatives and Senators Bricker and Lausche, urging support of the bill.

Even though the measure might not be voted upon in 1957, all bills carry over into 1958. If action is not taken this year there is a possibility the bill can be enacted in 1958.

The American Thrift Assembly, of which the AMA is a charter member, was organized in January by 27 professional and business associations. Its address is 1025 Connecticut Ave., N. W., Washington 6, D. C.

WHAT BILL DOES

If enacted, the Jenkins-Keogh bill would permit non-salaried professional and business persons to invest part of their income, before taxes, in a retirement plan, within limits. The person then would pay taxes only on the income from the investment after he retires. In most cases taxes would be lower since income after retirement is lower. The bill provides that earnings from the investment would be reinvested and, therefore, also would be n o n - t a x a b l e until retirement.

The bill, as introduced, would permit investment of 10 per cent of the investor's annual earnings, up to a maximum of $5,000. For older persons, that maximum is increased 10 per cent for each year over 50 years of age.

The bill would qualify investments in life insurance policies, including existing or new policies. Withdrawal of investments before retirement would incur taxes at penalty rates, if withdrawn before the investor reaches 65.

NATIONAL DRIVE LAUNCHED

The Treasury Department is opposed to the measure because of the loss in tax revenues, estimated by some as much as $275,000,000 a year.

The AMA is launching a drive to encourage all members of the medical profession to let their Congressmen and Senators know their feelings on the legislation. Similar campaigns have been opened by other professional organizations.

Pamphlets on the Jenkins-Keogh bill may be obtained by writing the American Thrift Assembly headquarters in Washington.

New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since April 1, 1957. The list shows the County in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ALLEN COUNTY
Maurice Converse, Lima
Thomas R. Wilson, Lima

BELMONT COUNTY
Werner Grauberg, Bellaire
Miklos Paal, Bellaire

BUTLER COUNTY
Walter R. deForest, Hamilton
Paul M. Woodward, Jr., Middletown

CUYAHOGA COUNTY
Robert E. Brooks, Cleveland
Louis D. Green, Cleveland
George P. Leicht, Cleveland
Ku-Yin Lin, Cleveland

DEFIANCE COUNTY
John W. Cullen, Defiance
Gerald A. Huber, Defiance

ERIE COUNTY
Harry L. Hoffman, Sandusky

FRANKLIN COUNTY
Earl T. Carter Columbus
John P. Crawford, Columbus
John A. Goodno, Fairborn
Herbert Knodt, Columbus
George H. Lohrman, Columbus
William O. Robertsom, Jr., Columbus

GALLIA COUNTY
George E. Files, Gallipolis

HAMILTON COUNTY
Jose G. Ibanez, Cincinnati
Howard B. McWhorter, Cincinnati
Alena M. Polesny, Cincinnati

HANCOCK COUNTY
Marion F. Detrick, Jr., Findlay
John C. Smithson, Findlay

JEFFERSON COUNTY
Harvey F. Grazier, Steubenville

LORAIN COUNTY
Albert Fisk, Elyria

LUCAS COUNTY
Armin E. Good, Toledo
Walter Pontasch, Toledo
Rolf H. Scholdager, Toledo
William A. Winslow, Toledo

MAHONING COUNTY
James H. Grove, Youngstown
Izydor Werbner, Youngstown

MONTGOMERY COUNTY
Norman L. Rose, Dayton
Charles B. Phillips, Dayton
Alan D. Shafer, Dayton
Albert M. Storrs, Dayton

STARK COUNTY
Alfred L. DeSanctis, Massillon
John R. McVey, Canton

TRUMBULL COUNTY
William G. Tobin, Warren

designed to **control anxiety**

in Arthritis, Asthma, Allergic Dermatoses

with **lower corticoid dosage**

the original tranquilizer-corticoid

Ataraxoid*

prednisolone and hydroxyzine



provides the emotional tranquilizer, ATARAX® (hydroxyzine) and the preferred corticoid, STERANE® (prednisolone) • control of emotional factors by tranquilization enhances response to the corticoid for greater clinical improvement • often permits substantial reductions in corticoid dosage, accompanied by reduction of hormonal side effects • confirmed by marked success in 95% of 1095 cases of varied corticoid indications[1]

ATARAXOID *now written as* **Ataraxoid 5.0**

5 mg. prednisolone, 10 mg. hydroxyzine hydrochloride, in green, scored tablets. Bottles of 30 and 100.

and now available as **NEW Ataraxoid 2.5**

2.5 mg. prednisolone, 10 mg. hydroxyzine hydrochloride, in blue, scored tablets. Bottles of 30 and 100.

and **NEW Ataraxoid 1.0**

1.0 mg. prednisolone, 10 mg. hydroxyzine hydrochloride, in orchid, scored tablets. Bottles of 100.

formerly **Ataraxoid**
NOW written **Ataraxoid 5.0**

advantages: (1) greater flexibility of dosage (2) effective tranquilization permits lower corticoid dosage

1. Personal communications

*Trademark

PFIZER LABORATORIES *Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York*

Pfizer

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

HOW TERM IS USED IS THE IMPORTANT FACTOR

Among questions which the Columbus Office gets from members asking for answers and information is this one: "What's a clinic?"

It's a tough question; subject to many varieties of answers. Setting up a universal definition is almost impossible. However, there are basic policies which apply to the "clinic" and the use of the term. Here's what the AMA Judicial Council has to say on the subject:

"The Judicial Council has stated before that it does not define terms that may connote ethical or unethical conduct. Nor does it believe it to be within its province to attempt to approve or disapprove, encourage or discourage particular forms of medical practice by definition. The Principles of Medical Ethics are themselves the criteria by which the ethical nature of professional conduct is determined. In connection with any definition of the word 'clinic,' it should be clear that regardless of how clinic is defined, each physician-member of the clinic must act, in his relations with his patients and his colleagues, in accord with all the Principles of Medical Ethics. No physician member of a clinic may permit the clinic to do that which he may not do. Each physician must observe all the Principles of Medical Ethics.

"Under the ethical principles of medicine no use may properly be made of the word clinic that would mislead or deceive the public, or would tend to be a solicitation of patients to the particular group of physicians holding themselves out as a 'clinic.'"

FULLY INFORMED, FAIRLY TREATED PATIENTS RARELY SUE

"There is no easy short cut to elimination of the malpractice menace. The incidence of claims may, however, be sharply reduced by an intelligent and determined program of education of each physician to his legal duties and to the irritants that create a suit-minded patient. Patients frequently forgive the accidents of medicine when they are fully informed and fairly treated. A patient who knows that his doctor is really interested in his welfare and is trying hard rarely sues."

So states Howard Hassard, general counsel of the California Medical Association, in an article "Professional Liability Claims Prevention," published by the *AMA Journal.*

It is easy to see that in the final analysis prevention rests with the individual physician, It's just like public relations. How well the physician gets along with his individual patients is the deciding factor in most instances.

LABOR DIAGNOSTIC CLINIC ADVISED AGAINST EXPANSION

Areas where labor unions may have started, or are contemplating starting, diagnostic clinics will be interested in the following editorial comment published in the April issue of the Toledo Academy of Medicine Bulletin, outlining the sound policy adopted by the academy on certain proposed steps to expand the scope of the clinics:

"Recently the Council of the Academy was asked to consider a proposal from the UAW-CIO Diagnostic Clinic concerning two expansions of the services of the Diagnostic Clinic.

"As it was originally proposed and established, the Diagnostic Clinic was to provide diagnostic services exclusively, and it was to examine union members or their families only if they were referred by private physicians.

"The Diagnostic Clinic now provides routine annual physical examinations for union members. It now asks Academy approval for free annual examinations for all dependents of union members, without referral by the family doctor.

"In answering this proposal, the Council fully realized that it has no authority to dictate to the UAW-CIO, but it does have a responsibility for maintenance of ethical practices in Lucas County, for promoting the best interests of Academy members, and for upholding high health standards in the community. It was suggested to the UAW-CIO Diagnostic Clinic, therefore, that annual physical examinations are desirable, but the examinee should have the privilege of choosing his own doctor for this purpose. It was further suggested that the Diagnostic Clinic should not perform routine annual examinations on the dependents of union members except with the express knowledge and consent of the private physician.

"The UAW-CIO also pointed out that retired union pensioners are not eligible for indigent or other welfare-supported medical services, and that pensioners often cannot afford private medical care. The Diagnostic Clinic therefore proposes to provide free medical treatment for such pensioners. The Council takes the stand that medical care is available to pensioners as well as to other persons who are "medically indigent," either free or at low cost, through existing facilities. These facilities include the out-patient

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departments of hospitals and low cost hospital beds provided in most hospitals.

"In addition, our Council assured the UAW-CIO that private physicians will give every consideration to the financial status of pensioners when making charges for medical care.

"For these reasons, the Diagnostic Clinic was urged not to enter the field of medical treatment, in which field it could offer no more than outpatient clinic care."

WISE APPROACH TO KNOTTY PROBLEM

The Academy of Medicine of Toledo and Lucas County is attacking with considerable planning a knotty problem that has plagued the medical profession everywhere. That problem involves convincing the layman that he should have a family physician, that to wait for an emergency before seeking a physician is sheer folly.

It is interesting to note that the Academy's president, Dr. Max T. Schnitker, writing in the March issue of the Academy's *Bulletin*, stresses that the approach is a "long range educational program . . . . to instruct the public that it is in the best interests" for every family to have a personal physician.

The problem is indeed one that requires long range efforts before it is solved. Experience has shown that heads of families who have no personal physicians need more than a reminder (many need some rather firm prodding) of the wisdom in having a family physician as emergency "insurance."

The article also points out another important segment of such a program: "Such a proposed program will require close cooperation within the entire medical profession to insure the promised coverage of emergency medical care."

In other words, a working arrangement for emergency medical care is a two-way street.

AMA Has TV Film Clips For News Programs

The American Medical Association has instituted a new television service—film clips for use on news programs, which are mailed to the stations direct.

A film report on medical aspects of drunken driving was mailed to a key list of 215 stations in March and was used on 88 different news programs during a 14-day period.

A $10,000 grant from the Ohio Association of Lions Club for its Eye Research Fund at Ohio State University was announced recently by Dr. W. H. Havener, acting chairman of the ophthalmology department. The grant brings to $30,575 the amount given to the university by the Lions since 1952.

Do You Know? . . .

Dr. Robert S. Dinsmore, prominent figure in the development of the Cleveland Clinic, has resigned as chief of surgery of that institution. He became chief of surgery in 1949, succeeding the late Dr. Thomas Jones. Active in professional activities, Dr. Dinsmore is a past-president of the Academy of Medicine of Cleveland.

* * *

Western Reserve University's Frances Payne Bolton School of Nursing will offer a special noncredit workshop in increasing the effectiveness of part-time personnel through the improvement of administrative practices June 24-28 on the Cleveland campus. The course is open to directors, supervisors and head nurses in hospital nursing services.

* * *

July 1, Dr. Richard F. Baer, resident physician at Ohio State University Medical Center, will become director of physical medicine and rehabilitation at Opportunity Home, the hospital operated in Toledo by the Toledo Society for Crippled Children.

* * *

Dr. Margaret Mead, New York City, widely recognized in the field of anthropology, has been added to the University of Cincinnati College of Medicine faculty as part-time visiting professor of anthropology to augment the teaching staff of the Department of Psychiatry.

* * *

Dr. Othilda Krug, associate professor of psychiatry at the University of Cincinnati, has been named president-elect of the American Association of Psychiatric Clinics for Children.

* * *

A memorial fund in honor of the late Henry S. Sherman, former chairman of the Board of Trustees of the Cleveland Clinic, has been established to help young doctors in training at the institution. By early April more than $13,000 had been contributed to the fund.

* * *

Dr. James T. Stephens, Oberlin, President of the Lorain County Medical Society, has been named a member of the five-member Advisory Council to the Division of Social Administration, Ohio Department of Public Welfare, for a term ending in January, 1962.

* * *

The American-Korean Foundation and the U. S. Army Medical Service have announced discontinuation of their project of shipping medical books to Korea. While the project was in progress over 77 tons, valued at $76,000, of medical texts, references and periodicals have been shipped to Korean medical schools.

VA Plans Reduction in Paper Work on Medical Program

The Veterans Administration is in the midst of steps to reduce paper work requirements in the VA's "Home Town Care" program, but participating physicians should not make any changes in present procedures until specifically authorized by the VA.

The "status quo" advice to physicians handling long-term outpatient treatment of service-connected disabilities comes from Dr. John G. Hood, VA Columbus area medical director.

The new system is aimed at sharply reducing billings and forms. It involves individually selected long-term patients and their doctors. Those doctors selected will receive authorization from the VA to continue treatment for periods up to one year, instead of the present system of having to submit a monthly request to continue treatment. The doctors may submit reports to the VA on the medical condition of patients at the end of three months, instead of monthly as at present.

Also, these doctors may submit monthly bills to a VA regional office on the individual doctor's letterhead instead of on VA forms.

Selected veterans in the hometown program who must travel to nearby cities to visit medical specialists will receive travel authorization to cover the entire authorized treatment period instead of the present monthly travel authorization.

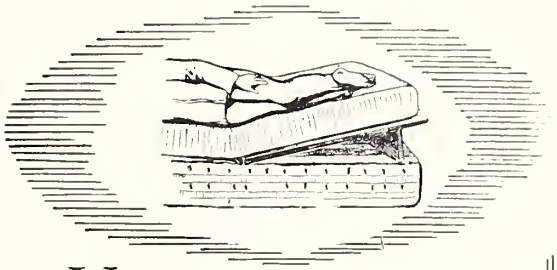
Veterans who may be placed under the new system are those already receiving treatment under the hometown program for service-connected disabilities requiring extended treatment, such as diabetes, chronic chest conditions, gastrointestinal and vascular diseases, and neurological conditions.

Dr. Hood said the selection of patients under the simplified authorization plan will be made by the chief medical officer of the VA regional office or outpatient clinic. He said physicians authorized to treat specific patients under the new plan will receive detailed instructions explaining the new procedures.

The VA anticipates that screening of outpatient cases will be completed by July 1, and that all suitable cases will be enrolled in the new procedure by that time. After that date, a participating physician who feels he is treating veterans who could be enrolled in the new procedure is invited to submit his recommendations to his nearest VA regional office or outpatient clinic.

The first 12 months of the added penny excise tax per pack of cigarettes brought into the Ohio treasury an extra $11,643,619, State Treasurer Roger W. Tracy announced. The excise was voted to finance the $150 million bond issue for construction of schools and mental institutions.

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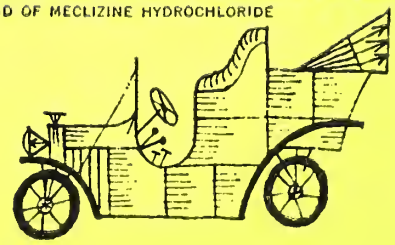
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In Memoriam . . .

Edward V. Arbaugh, Sr., M. D., Martins Ferry; College of Physicians and Surgeons of Baltimore, 1900; aged 81; died April 3; former member of the Ohio State Medical Association. A native of Martins Ferry, Dr. Arbaugh served all of his professional career there. Even his internship was served at nearby Wheeling. Active in community affairs, he was a member of the Fraternal Order of Eagles for which he was physician many years, and a member of the Catholic Church. His three sons are professional men. They are Edward V. Arbaugh, Jr., M. D., St. Clairsville; Charles F. Arbaugh, D. D. S., and James J. Arbaugh, M. D., both of Martins Ferry. Other survivors are his widow, two daughters and a sister.

Halbert Brush Blakey, M. D., Columbus; Rush Medical College, 1906; aged 78; died April 10; former member of the Ohio State Medical Association and the American Medical Association. Dr. Blakey served all of his professional career in Columbus with time out for study abroad and for service in the Medical Corps during World War I. He had been presented the 50-Year Award of the Ohio State Medical Association. Formerly associate professor of medicine at Ohio State University, he was active in a number of organizations including Phi Delta Theta, Phi Rho Sigma, the Rotary Club, Athletic Club, Columbus Country Club and the Young Men's Business Club. Survivors include his widow and a son.

Galen G. Crozier, M. D., Middletown; University of Michigan Medical School, 1899; aged 89; died April 18. Dr. Crozier had been living in Middletown since his retirement in 1948, after serving nearly 50 years in India as missionary for the Baptist Church. He is survived by his widow, a daughter and a sister.

Colin R. Clark, M. D., Youngstown; University of Pennsylvania School of Medicine, 1895; aged 87; died April 23; former member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Physicians and diplomate of the American Board of Internal Medicine. Dr. Clark moved to Youngstown early in his career, where he was active in expansion of the Youngstown Hospital Association and in the affairs of the Mahoning County Medical Society. During World War I he served overseas and attained the rank of lieutenant colonel. Organizations with which he was associated included the National Tuberculosis Association, the Youngstown Hearing Society and the American Red Cross. A member of the Presbyterian Church, he is survived by his widow, two daughters and two sisters.

Earl Mitchell Culter, M. D., Cincinnati; Miami Medical College, Cincinnati, 1909; aged 70; died April 23; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A native of Ripley, Dr. Culter practiced for six years in Houston, Texas, prior to World War I. After service during the war, he returned to the Greater Cincinnati area where he practiced in Carthage. He was a member of the American Legion. His widow survives.

John Walker Fairing, M. D., Cleveland; Baltimore Medical College, 1898; aged 85; died April 12. A former practicing physician in Greensburg, Pa., Dr. Fairing retired in 1950 and moved to Cleveland. Survivors include a daughter with whom he resided, a son and a brother.

George W. Flory, M. D., Eaton; Physio-Medical College of Indiana, Indianapolis, 1888; aged 94; died April 12; member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award; for many years delegate of the Preble County Medical Society to the OSMA House of Delegates. A practicing physician for more than 60 years, Dr. Flory was Preble County Coroner for 20 years. He was a member of the Masonic Lodge. His widow and a son survive.

Robert F. Fuller, M. D., Marysville; Ohio State University College of Medicine, 1951; aged 35; died April 8 as the result of a traffic accident; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Fuller had practiced in Marysville for five years. He was a member of the Columbus Society of Anesthesiologists, Phi Chi, the American Legion and several Masonic bodies. He was an organizer of the Union County Mental Health Association and a director of the Central Ohio Mental Health Clinic. Survivors include his widow, a son, his parents, a sister and two brothers.

Enoch Herbert Harsh, M. D., Minerva; Baltimore Medical College, 1901; aged 80; died April 17; former member of the Ohio State Medical Association and the American Medical Association; member of the American Urological Association. A practicing physician in Cleveland from 1916 to 1952, Dr. Harsh retired in the latter year and moved to Minerva. He was a veteran of World War I, having served with the Army Medical Corps. Affiliations included memberships in several organizations among them the Methodist Church and a number of Masonic bodies. His widow survives.

Victor Ellsworth Hillegass, M. D., Akron; Ohio State University College of Medicine, 1940; aged



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44; died April 12; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A resident of Akron for most of his life, Dr. Hillegass practiced there from the time he completed his medical training. During World War II he served as captain with the Army Medical Corps. He was a member of Lambda Chi Alpha and the Evangelical and Reformed Church. Survivors include his widow, three daughters, his mother, grandmother and two brothers.

Ernest Alfred Kellen, M. D., Indianapolis, Ind.; St. Louis University School of Medicine, 1948; aged 51; died in March; former member of the Ohio State Medical Association and the American Medical Association; member of the American Psychiatric Association. Dr. Kellen formerly was on the staffs of the Columbus State Hospital and the Apple Creek State Hospital. He joined the staff of the Central State Hospital in Indianapolis in 1955.

Samuel C. Lindsey, M. D., Cleveland; Western Reserve University School of Medicine, 1893; aged 85; died March 30; member of the Ohio State Medical Association and the American Medical Association. Dr. Lindsay was a practicing physician for many years in Cleveland.

Ned D. Shepard, M. D., Dayton; Ohio State University College of Medicine, 1936; aged 46; died April 18; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A native of Montgomery County where his father, the late Dr. Clarence Shepard practiced, Dr. Ned Shepard served all of his professional career in the Dayton area. He was active in the work of the Montgomery County Medical Society and was delegate of that organization to the OSMA for several years. A member of the Lutheran Church and several Masonic bodies, he is survived by his widow, a son, two daughters, his mother and a brother.

Francis X. Siegel, M. D., Cincinnati; Miami Medical College, Cincinnati, 1907; aged 75; died April 10; member of the Ohio State Medical Association, the American Medical Association, the American Academy of Ophthalmology and Oto-Laryngology, International College of Surgeons; Fellow of the American College of Surgeons; diplomate of the American Board of Ophthalmology. A practicing physician in Cincinnati for all of his professional career, Dr. Siegel would have completed 50 years of practice this year. He was a member of the Catholic Church, the Knights of Columbus and the Medievalists and in 1951 was named by the Pope as a Knight Commander of the Order of St. Gregory. He is survived by his widow and a daughter.

Richard E. Sinkey, M. D., Toledo; University of Michigan Medical School, 1911; aged 70; died April 15; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Toledo for 45 years, Dr. Sinkey was a veteran of World War I, during which he served with the Army Medical Corps. During World War II he served with Selective Service. Affiliations included memberships in the Methodist Church and several Masonic bodies. Survivors are his widow; a son, Dr. John R. Sinkey, also of Toledo, and a brother.

Lee B. Warren, M. D., Lorain; Ohio State University College of Medicine, 1918; aged 77; died April 16. Dr. Warren practiced in the Lorain area for many years beginning in 1918. He was in ill health for about the last 10 years. His widow survives.

George W. Yauger, M. D., Dayton; University of Cincinnati College of Medicine, 1936; aged 51; died April 24; member of the Ohio State Medical Association. Dr. Yauger was a practicing physician in the Dayton area for many years and was a veteran of World War II. He is survived by a daughter, his father and a sister.

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What To Write For

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* * *

General Information Concerning Patents. Booklet is not for patent lawyers but for investors and prospective applicants for patents, and gives them a brief introduction to the subject (15 cents). Write Superintendent of Documents, Washington 25, D. C.

* * *

Statistical Bulletin: Volume 37; 1956. Deals with statistical analyses of mortality causes, rates, frequency of various illnesses, and many other subjects of interest to the medical profession. Write Metropolitan Life Insurance Co., One Madison Ave., New York 10.

* * *

Research Relating to Children. Lists studies in progress on research programs, physical and motor development, intelligence, behavior and personality, education, health services, and social services. (75 cents) Write Superintendent of Documents, Washington 25, D. C.

* * *

How to Write a Health Column. Pamphlet on suggestions as to contents and format of a column, prepared by W. W. Bauer, M. D., director, Bureau of Health Education, AMA, and editor of *Today's Health*. Write AMA Bureau of Health Education, 535 N. Dearborn St., Chicago 10, Ill.

* * *

AMA Publications about Your Health. Complete list of AMA health pamphlets and booklets. List is indexed according to subject material as well as by titles. Write Ohio State Medical Association, 79 E. State Street, Columbus 15, Ohio.

* * *

Stop Worrying about Health. Of 3,500 executives examined, 40 to 45 per cent had non-existing ailments, indicating amount of needless worry. Article also discusses value of periodic physical examination, particularly as a company program (10 cents). Write Nation's Business, 1615 H Street N. W., Washington 6, D. C.

* * *

Why the 40-Plus Patient Needs More Vitamins. Booklet details role of vitamins in conditioning this age group, stressing protection vitamins give, particularly to circulatory, nervous, digestive, hemopoietic, skeletal and endocrine systems. Write "40-Plus" Department, Chemical Division, Merck & Co., Inc., Rahway, N. J.

Former Cincinnatian Is Medical Director of AHA

Dr. Eugene B. Ferris, Jr., former Cincinnatian, is the new medical director for the American Heart Association. Dr. Ferris spent 17 years at the University of Cincinnati, becoming professor in the Department of Medicine of the College of Medicine. He was active in many projects in Cincinnati, including programs of the AHA.

Dr. Ferris left Cincinnati in 1952 to become professor of medicine and chairman of the Department of Medicine at Emory University School of Medicine, Atlanta, Ga.

Obstetrics and Gynecology

Applications for certification by the American Board of Obstetrics and Gynecology, new and reopened, for the 1958 Part I Examinations are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline date for receipt of applications is September 1, 1957. No applications can be accepted after that date.

Current Bulletins outlining present requirements may be obtained by writing to the secretary's office: Robert L. Faulkner, M. D., American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

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The Medical Secretary . . .

Her Duties, Training and Role on Medical Team Outlined in Report Of Recent National Study Aided by American Medical Association

THE key to improved efficiency in a physician's office may be in the hands of his medical office personnel, a nationwide survey reveals.

The study was conducted by Harold Mickelson, Northeast Missouri State Teachers College, in cooperation with the American Medical Association. Mickelson completed the study in connection with his work toward a Doctor of Education degree at Indiana University.

Are medical secretaries and assistants properly trained for their jobs? Does the physician-employer properly delegate duties to office personnel to make best use of individual skills and training? Are there tasks which the physician should assign to an aide in order to give him more time to see patients?

MAIL QUESTIONNAIRE

These are some of the questions which are answered in Mickelson's study conducted to determine the ideal knowledges, skills and personal qualities of medical secretaries. Conclusions were based on mail-questionnaire information supplied by approximately 500 top-notch medical secretaries and on personal interviews with physicians and business educators.

THREE CATEGORIES OF ACTIVITIES

Mickelson analyzed those activities performed in physicians' offices, classifying them into three categories: (1) highly technical medical activities which under normal conditions only a physician can perform; (2) semitechnical medical activities which may be performed satisfactorily by medical office personnel under the supervision of the physician, and (3) business office activities of a routine or management nature which are ideally performed by the secretary or aide.

Mickelson concludes that "physicians are not making maximum use of their extensive training when they unnecessarily perform semi-technical medical and business activities." To help physicians determine what responsibilities can be properly delegated to office personnel, Mickelson is currently preparing a system for assigning duties which will be furnished by AMA to medical societies.

HOW SECRETARY CAN HELP

A highly competent secretary, he believes, can relieve a physician of performance of all or nearly all business—office and semi-technical medical activities connected with his practice. The physician, however, still remains responsible for supervision of these activities.

Physicians interviewed agree with Mickelson. One doctor expressed the opinion that "there is almost no ceiling to the responsibility that an outstanding secretary can take over for a physician." Another said: "There is no practical way to practice medicine today without a medical secretary." The consensus was that it is penny-wise and pound-foolish to employ an incompetent aide.

HOW ABOUT TRAINING?

Where can girls get proper medical secretarial training? What kind of schools should offer training to medical aides? Mickelson believes training should be at the post-high-school level and that a four-year college-degree training program is preferable to a shorter course.

According to Mickelson, only schools with strong business training and strong science departments can offer the kinds of courses and the quality of training that is desirable. His recommendations for course content include development of high-level competency in all generally accepted secretarial skills, business office activities peculiar to the medical office, and all semitechnical activities ordinarily performed by physicians' employees. Semitechnical activities are those related to the examination or treatment of patients, weighing patients, taking temperatures and blood pressures, assisting with minor office surgery or treatment procedures, giving certain types of injections, sterilizing instruments, and conducting some laboratory tests, such as urinalysis and simple blood tests.

PERSONAL QUALITIES

Students also must develop certain personal qualities important to their particular job success. These personal qualities were listed by physicians in interviews and are considered necessary in the good medical secretary or aide. They include: pleasantness, neatness, ability to get along with people, ability to use the telephone effectively, intelligence, politeness, ability to keep secrets, interest in and feeling for people, initiative, honesty, enthusiasm, interest in medical work, loyalty, cooperation, conservatism, pleasant voice, self-confidence, ability to make decisions, ability to instill confidence, willingness to continue to learn on the job, dependability, pa-

tience, aggressiveness (must not be shy), accuracy, memory, maturity, and a sense of humor.

HOW MEDICAL SOCIETIES CAN HELP

On the basis of the survey, a number of steps which medical associations and medical secretary-assistants groups can take to help provide a greater force of better-trained aides in the future are suggested:

1. Encourage schools with the necessary personnel and facilities to offer high-quality medical secretarial training.
2. Recruit high school graduates for high-quality medical secretarial training.
3. Organize or assist in organizing refresher courses in medical office administration for the employed medical secretary and assistant.
4. Persuade individuals currently employed as medical secretaries to increase their effectiveness on their jobs through additional training in school and/or on the job.
5. Point out to physicians the importance of employing well-qualified medical secretaries and remunerating them adequately.

Copies of the Mickelson report may be obtained from the Public Relations Department of the American Medical Association, 535 North Dearborn Street, Chicago.

Ohio Institutions Benefit From Life Insurance Heart Grants

Awards totalling more than one million dollars have been allocated for heart research this year by the Life Insurance Medical Research Fund, it was announced by Dr. Francis R. Dieuaide, scientific director of the fund. This is the first time that the annual awards have passed the million-dollar mark.

In all, the Fund has given $9,211,000 for heart research since it was organized in 1945, including the 1957 awards of $1,059,490.

Grants in Ohio include the following:

Ohio State University Research Foundation, Columbus for research by Dr. Francis W. McCoy on the juxtaglomerular apparatus of the kidney, $10,560.

Saint Luke's Hospital Association, Cleveland, for research by Dr. Frederick S. Cross on direct vision surgery for lesions of the mitral and aortic valves of the heart, $16,500.

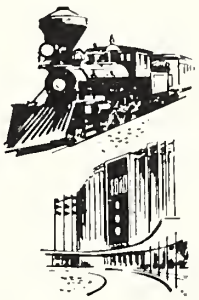
University of Cincinnati College of Medicine, for research by Dr. Julius B. Kahn, Jr., on the relations between potassium transport and work capacity of the heart, $13,640.

University of Cincinnati College of Medicine, for research by Dr. William D. Lotspeich on phlorizin in relation to tubular transport in the kidney, $18,700. A postdoctoral fellowship also went to Dr. Daniel M. Keller, Redmond, Wash., for study with Dr. Lotspeich on the same project.



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Activities of County Societies . . .

First District

(COUNCILOR: FRANK H. MAYFIELD, M. D., CINCINNATI)

ADAMS

The Adams County Medical Society met on April 24 at the Adams County Hospital in West Union, with luncheon in the hospital dining room. Speaker for the occasion was Dr. Charles A. Sebastian, Cincinnati, who spoke on "The Medical Aspects of Disaster Health Services in Adams County." Dr. Sebastian is the Division director of the Ohio Civil Defense Corps in that region. Nurses and other medical personnel attended the meeting.

Also speaking on the program was Robert Siler, administrative director of Area I of the Ohio Civil Defense. Other guests included civil defense personnel and the personnel of the Adams County Health Department and Hospital.

CLINTON

The following report is quoted from the *Wilmington News Journal:*

Reports of conferences in widely scattered places attended by members of the Clinton County Medical Society were heard at the luncheon meeting Tuesday (April 2) at the General Denver Hotel. Dr. H. Richard Bath described the mediclinic on general practice he attended at Ft. Lauderdale, Florida. Dr. Foster J. Boyd spoke about the meeting of the American College of Surgeons in Washington, D. C., and of his visits to medical installations, such as the Armed Forces Medical Institute and Department of Health, he had found extremely interesting there. Dr. Robert M. Cronebaugh of Blanchester spoke on the Academy of General Practice conference he had attended in St. Louis, Mo.

HAMILTON

A joint meeting of the Academy of Medicine of Cincinnati and the Heart Council was held on April 2. The subject, "Diagnosis of Unusual Forms of Heart Disease," was discussed by Dr. Howard B. Burchell, professor of medicine, Mayo Foundation, Rochester, Minn.

On May 7 the Roger Morris Lecture was given by Dr. Joseph W. Jailer, associate professor of medicine, Columbia University. His topic was, "Basic Etiology of Hyperadrenalism."

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

CLARK

The Clark County Medical Society will conduct a survey of hospital beds available and doctors available per capita in the Springfield area. Dr. Howard E. Sanders will head the survey committee as chairman.

This action came at the Medical Society's April general meeting held in Hotel Shawnee, Springfield.

Society President Dr. John LeFevre appointed Dr. Sanders to the committee.

By a unanimous vote two doctors, Harry Berley and Bernard J. Begley, were voted members of the Clark County group.

Guest speaker for the meeting was Dr. Edward Ellison, associate professor of surgery at Ohio State University. His topic was "Preoperative Evaluation of the Poor Risk Patient."

Dr. Paul W. Schanher, Jr., told members that a Clark County blood assurance program is available for them at City Hospital. Dr. Schanher, who heads the blood assurance group, made the statement in a report of the program's progress in Springfield and Clark County.—Tom Duross.

DARKE

The Darke County Medical Society met on April 16 in the Treaty City White Shrine Temple in Greenville. Speaker was Dr. Alan Shaffer, Dayton, whose subject was "Emergencies in the Newborn."

MIAMI

The annual joint dinner meeting of the Miami County Medical Society with the Woman's Auxiliary was held at the Troy Country Club on May 9. Loren Schultz, news editor of the *Springfield Daily News*, spoke to the combined meeting on the subject "Teamwork Between the County Medical Society and the Press."

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

LOGAN

The regular meeting of the Logan County Medical Society was held last Friday evening (April 5) at Mary Rutan hospital with the president, Dr. Charles H. Thompson of West Mansfield, presiding.

For the program Dr. Hobart L. Mikesell of West Liberty discussed and presented three cases of histoplosmosis.—*Bellefontaine Examiner.*

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

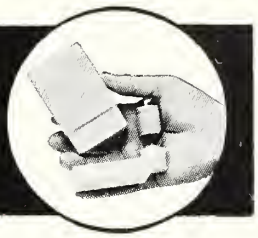
The May schedule of the Academy of Medicine of Toledo and Lucas County contained the following features:

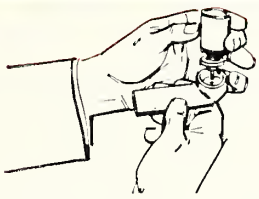
May 2 and 3—The Inter-Hospital Postgraduate Series. Guest speaker was Dr. Lauren V. Ackerman, professor of surgical pathology and path-

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Riker LOS ANGELES

ology, Washington University School of Medicine, St. Louis. The theme for the series was "The Modern Pathologist and His Relationship to Surgery."

May 10—Specialties Section. A panel discussion on the subject "Light Sensitive Dermatoses," was held with the following panel participating: Drs. Jerome Kimmelman, Francis Epstein, Walter Greenson and William Eyster. Chairman was Dr. L. R. Cranmer, and secretary, Dr. J. W. Smythe.

May 23—Toledo Venereal Disease Seminar, sponsored jointly by the Academy of Medicine, Toledo-Lucas County Academy of General Practice, Toledo Health Department and Ohio Department of Health.

Dr. Max Schnitker, presided, with the following persons speaking on the topics indicated in the early afternoon:

"Let's Talk About VD," Dr. C. J. A. Paule, chief of the Bureau of Preventive Medicine, Toledo Health Department.

"Epidemiology of Syphilis," Dr. F. H. Wentworth, chief of the Division of Communicable Diseases, Ohio Department of Health.

"Diagnosis of Syphilis and Differentiation of Early and Late Lesions from Other Manifestations," Dr. A. P. R. James, consulting dermatologist and syphilologist, Toledo Health Department.

Dr. Thad Taylor presided over the late afternoon session with the following persons discussing topics indicated:

"Venereal Disease Laboratory Tests and Their Interpretation," Dr. Charles R. Rein, special consultant for the U. S. Public Health Service and member of the faculty at New York University Post-Graduate School of Medicine.

"Management of Syphilis and Gonorrhea," Dr. L. W. Shaffer, director, Social Hygiene Division, Detroit Health Department, and professor of dermatology and syphilology, Wayne State University.

Following dinner at the Toledo Club, the group reconvened for a program. A panel discussion with the foregoing speakers participating was presided over by Dr. Paule.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

ASHTABULA

On Tuesdady evening, April 9, the Ashtabula County Medical Society had its monthly dinner at the Ashtabula Hotel. Guests for the evening were members of the Ashtabula County Bar Association, who in October, 1956, had played host to the Medical Society.

President of the Ashtabula County Medical Society, Dr. Harold Franley was in charge of the

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meeting, which showed a fine turn-out, and promises to be an annual affair.—O. J. Lighthizer, M.D., Correspondent.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

A meeting devoted to Workmen's Compensation was held by the Mahoning County Medical Society on April 16 in the Youngstown Elks Club. The afternoon program included secretaries and other physicians' aides. Speaker for the occasion was Clark C. Grubbs, assistant deputy claims administrator for the Ohio Bureau of Workmen's Compensation. His part of the program was a workshop with practical suggestions in handling Workmen's Compensation fee bills and claims.

Secretaries attended a noon luncheon while doctors had their dinner meeting in the evening.

A group of approximately 73 members and guests of the Society visited Parke, Davis & Company in Detroit, as guests of the pharmaceutical firm, May 1 and 2.

On April 1 members of the Society met with druggists of the county to discuss mutual problems and set up a second panel discussion in the fall. More than 160 persons attended.

SUMMIT

"Medical Hypnosis," was the subject of discussion at the May 7 meeting of the Summit County Medical Society. The speaker was Dr. Seymour Hershman, member of the attending staff of Garfield Park Community Hospital, Chi-Chicago, and formerly Veterans Administration research assistant in hypnosis. Dinner was served at the Akron City Club, with the meeting following at the Akron General Hospital Auditorium.

TRUMBULL

The April meeting of the Trumbull County Medical Society was held April 17. It was as usual, a dinner meeting.

An interesting discourse on arterial injuries, and the use of arterial grafts, was presented by Dr. Frank K. Inui of Youngstown, Ohio. Dr. Inui had considerable experience in arterial grafting, and arterial injuries during the Korean conflict.

Plans for the coming county fair had been previously formulated. In regard to Medical Society participation, plans are also in effect to attempt the setting up of a speakers' bureau to handle the many requests of our civic organizations for medical speakers.—Ralph H. Jamison, M. D., chairman, Public Relations.

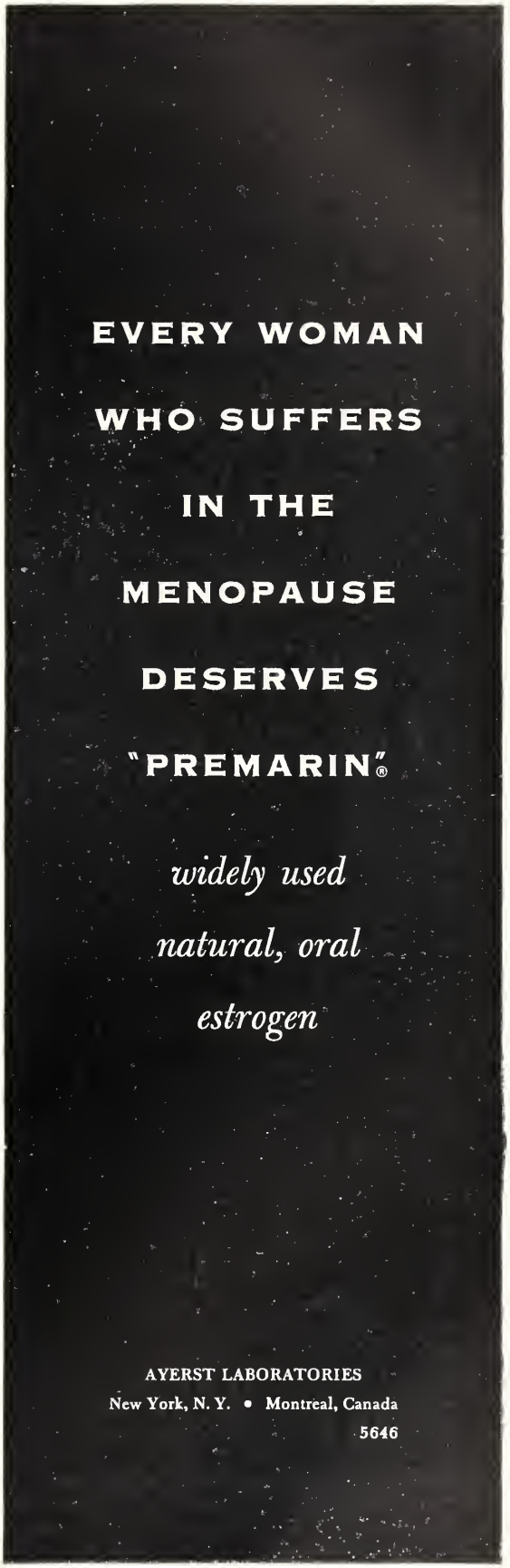
Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D., LANCASTER)

GUERNSEY

The Guernsey County Medical Society met on April 4 in the Berwick Hotel, Cambridge, for a luncheon meeting.

Dr. Howard Miller commented on the annual



meeting of the American Academy of General Practice which he attended in St. Louis.

The scientific portion of the program was presented by Dr. M. Orlowsky with a film on treatment of infections.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

Dr. A. W. Humphries, of the Department of Surgery, Cleveland Clinic, was guest speaker at the April 8 meeting of the Scioto County Medical Society in Portsmouth. He spoke on the subject, "The Present Status of Major Arterial Grafting." The meeting was held in the Nurses' Recreation Hall of General Hospital, with a buffet supper.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

The Lorain County Medical Society was scheduled to hold its 10th annual medical symposium at the Spring Valley Country Club on May 29. Following is the program, all participants being members of a team from Ohio State University College of Medicine:

Opening remarks by Dr. James T. Stephens, president of the Society, and chairman of the program.

"Anesthesia and Analgesia in Obstetrics," Dr. James Matson, Department of Surgery.

"The Modern Treatment of Asthma," Dr. William F. Mitchell, clinical professor, Department of Medicine.

"Surgical Aspects of Granulomatous Lesions of the Bowel," Dr. Roger Williams, assistant professor, Department of Surgery.

"Current Thought on the Relationship of Cholesterol Metabolism and Atherosclerosis," Dr. Bernard H. Marks, assistant professor, Department of Physiological Chemistry and Pharmacology.

After dinner, Dr. Robert Stevenson, assistant professor in the Department of Psychiatry, spoke on the subject, "The Use of Tranquilizing Drugs."

Course in Radiation for Doctors and Lawyers Scheduled at UC

A one week course in radiation for industrial physicians and lawyers will be offered by the Institute of Industrial Health and the College of Law of the University of Cincinnati during the week of September 9. This course, the first of its kind, is directed at the two professions simultaneously in order to enable each to understand the problems, professional responsibilities and limitations of the other when dealing with medical or legal problems that are posed by the use of ionizing radiation.

Dr. Lincke Represents AMA Before London Medical Congress

A distinction was accorded one of Ohio's delegates to the American Medical Association when Dr. Carl A. Lincke, of Carrollton, was designated official representative of the AMA to the Harvey Tercentenary Congress scheduled at the Royal College of Surgeons in London, England, June 3-7.

Dr. Lincke is a Past-President of the Ohio State Medical Association and has served several times as AMA delegate. His trip abroad carried with it double responsibility. Leaving home April 29 he first attended the Rotary International Assembly at Lake Placid, N. Y., and went abroad as a delegate of that organization to the Rotary International Convention at Lucerne, Switzerland, May 19-23. Dr. Lincke is a district governor of Rotary.

The trip abroad, on which Dr. Lincke was accompanied by Mrs. Lincke and their daughter Ann, included tours through Spain, Italy, Germany, and France as well as Switzerland and England. The trip home was scheduled on the *Queen Elizabeth*.

The London Congress commemorates the 300th anniversary of the death of William Harvey. History will be made in medical communications when portions of a London symposium on the results of cardiac surgery is carried by trans-Atlantic cable to New York where physicians attending the AMA Session will compose the audience.

Foundation for Premedical Education At Wesleyan Headed by Dr. Perry

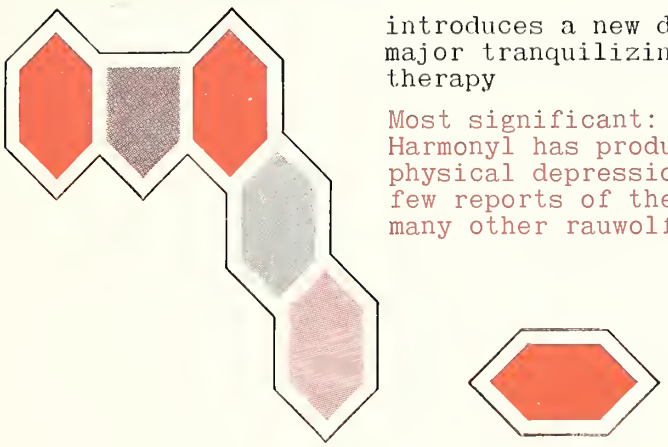
Dr. Claude S. Perry, Columbus, is the new chairman of the Rice Foundation for Premedical Education, an organization composed of 495 physicians who obtained their premedical education at Ohio Wesleyan University, Delaware. The Foundation was established in November, 1953, in honor of Dr. Edward L. Rice, professor of zoology at the University, 1898 - 1941. Dr. Winchell McK. Craig, Rochester, Minn., has been chairman of the Foundation since 1953.

Over 100 physicians, premedical students and members of the Ohio Wesleyan faculty attended the Spring meeting of the Foundation which was held at Delaware. They heard an interesting panel discussion on "Recent Trends in Medical Education and Their Implications for Premedical Education." Dr. Craig was the moderator. The panelists were: Dr. Richard L. Meiling, associate dean, Ohio State University College of Medicine, Columbus; Dr. John W. Patterson, dean, University of British Columbia Faculty of Medicine, Vancouver, B. C., and Dr. Lawrence E. Young, professor of medicine, University of Rochester School of Medicine and Dentistry, Rochester, N. Y.

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Of particular interest is the observation that patients became more lucid and alert on Harmonyl therapy. And there was a complete absence of side effects with Harmonyl—although a similar group on reserpine developed such side effects as anorexia, headache, bizarre dreams, shakes, nausea and vomiting.

Following another eight-month study of chronic, hospitalized mental patients, Ferguson[2] stated:

- Harmonyl benefited at least 15% more overactive patients and proved more potent in controlling aggression—requiring only one-half to two-thirds the dosage of reserpine.
- Patients experiencing side reactions on reserpine often were completely relieved when changed to Harmonyl.

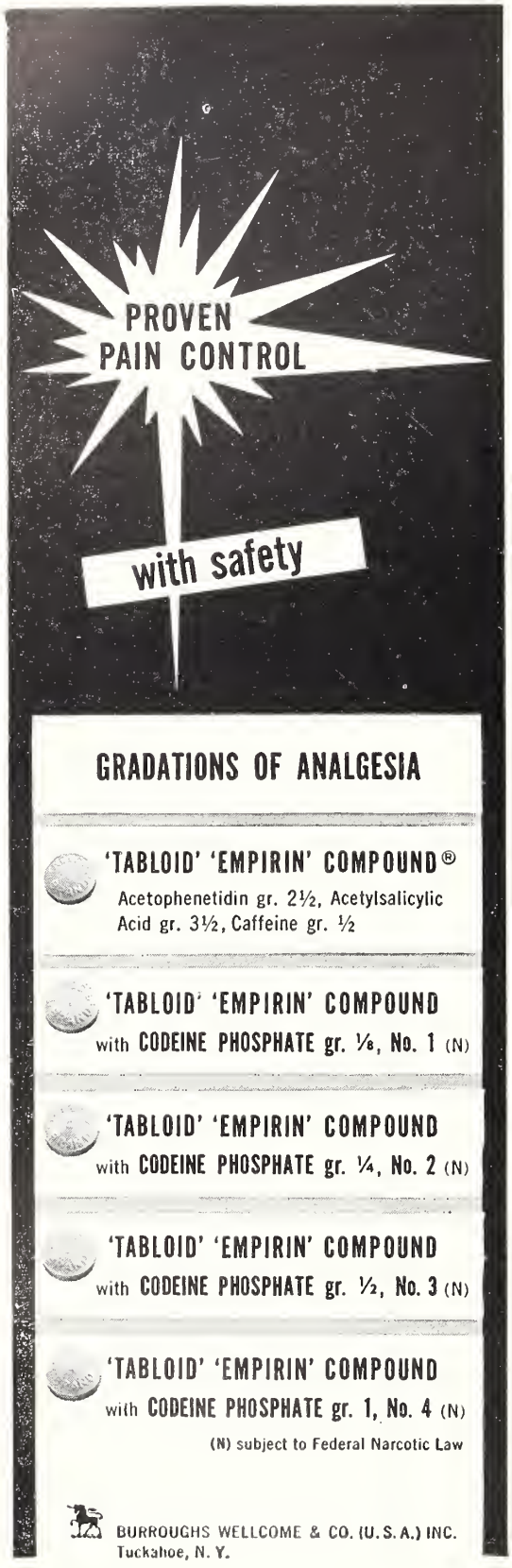
Ferguson concluded: "*The most notable impressions were the absence of side effects and relatively rapid onset of action with Harmonyl.*"

Comparative studies have shown Harmonyl and reserpine about equal in hypotensive effect. The tranquilizing action of the two drugs also appeared similar—except that few cases of giddiness, vertigo, sense of detached existence or disturbed sleep were seen with Harmonyl.

Professional literature is available upon request. Harmonyl is supplied in 0.1-mg., 0.25-mg., and 1-mg. tablets. Abbott

References: 1. Communication to Abbott Laboratories, 1956. 2. Ferguson, J. T.: Comparison of Reserpine and Harmonyl in Psychiatric Patients: A Preliminary Report, Journal Lancet, 76:389, December, 1956. *Trademark

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Activities of Woman's Auxiliary . . .

CHAIRMAN, PUBLICITY COMMITTEE—Mrs. Carl F. Goll, 1001 Granard Parkway, Steubenville, Ohio

ALLEN

The Allen County Auxiliary held an evening meeting on April 23 at the home of Mrs. T. L. Edwards with Mrs. J. D. Albertson, Mrs. M. A. Mulvania and Mrs. R. O. Page assisting the hostess.

The speaker was Dr. Anna H. Koffler, professor in pharmacy at Ohio Northern University. Her topic was "Happy Pills."

The annual "Scholarship Ball" was held April 25 at the Shawnee Country Club. Proceeds from this dance go into the Nurses' Loan Fund.

BUTLER

Members of the Woman's Auxiliary to the Butler County Medical Society enjoyed a luncheon and meeting at Gray Gables, Oxford, on April 16. Mrs. Gilbert Wagoner presided in the absence of the president, Mrs. Herbert Warm.

New officers presented were as follows: Mrs. Wagoner, president; Mrs. Edward Kezur, president-elect; Mrs. John Sawyer, corresponding secretary; Mrs. Walter Fening, recording secretary; Mrs. Rodney Caudill, treasurer; Mrs. E. T. Storer, director.

Marcel Martin, Paris, France, special student in economics at Miami University, and a member of the school's Speaker Bureau, gave an interesting and informative talk on the social security program in France.

CLINTON

The Medical Auxiliary to the Clinton County Medical Society held a luncheon meeting April 4 at the General Denver Hotel.

The nominating committee for next year's officers reported as follows: Mrs. Plymire, president; Mrs. Hale, vice-president; Mrs. R. M. Cronebaugh, president-elect; Mrs. Regan, secretary, and Mrs. R. R. Buchanan, treasurer.

The Hospital Ball given each year by this Auxiliary for the benefit of Clinton Memorial Hospital was held at Snow Hill Country Club on April 27. Mrs. H. R. Bath was general chairman, and Mrs. W. L. Wead was co-chairman.

COSHOCTON

The Woman's Auxiliary to the Coshocton County Medical Society met on the evening of April 9 at the home of Mrs. A. H. Magness. This annual business meeting included reports from each of the committees. *Today's Health* chairman reported that the Auxiliary has sold 308 per cent of the quota for the year, putting them in the "More Exclusive Club" in the AMA

Auxiliary. A short discussion on Legislation was included in this meeting.

Election of officers was held with Mrs. Robert R. Johnson being named president; Mrs. Norman L. Wright, president-elect; Mrs. John Magness, secretary; and Mrs. A. H. Magness, treasurer.

COLUMBIANA

A western theme set the mood April 6 for the Spring Roundup dance sponsored by the Woman's Auxiliary of the Columbiana County Medical Society. Some 150 attended the benefit event at the Country Club.

Proceeds will be used for the national Auxiliary's American Medical Education Fund. The committee included Mrs. H. F. Banfield, chairman, Mrs. K. W. Turner, Mrs. Janis Lauva, Mrs. J. Fraser Jackson, Mrs. Wm. S. Banfield and Mrs. Wm. Horger.

CUYAHOGA

The Woman's Auxiliary to the Cleveland Academy of Medicine of Cuyahoga County recently closed its Syringe Bank, which they had in operation for ten weeks. The bank, at St. Luke's Hospital, had 25,000 syringes for the administration of polio vaccine to schoolchildren of Cuyahoga County.

More than 100 members of the Auxiliary volunteered their services for the work involved. Each week a graduate nurse, who was an Auxiliary member, was in charge of the operation of the bank. This involved sterilizing the syringes, packing in kits of 175, and issuing them to the various schools.

Mrs. C. A. Colombi, chairman of the committee in charge of the bank, reported that they had processed 285,000 syringes, and used 2,000 volunteers.

FAIRFIELD

New officers were named when the Woman's Auxiliary to the Fairfield County Medical Society held a luncheon April 8 in Hotel Lancaster.

Mrs. George Le Sar is the new president of the organization; Mrs. G. Fred Jones, president-elect; Mrs. Charles Clark, vice-president; Mrs. Kenneth Gaines, secretary; Mrs. William Boswell, treasurer. The historian's book was on display, prepared this year by Mrs. George Mogil.

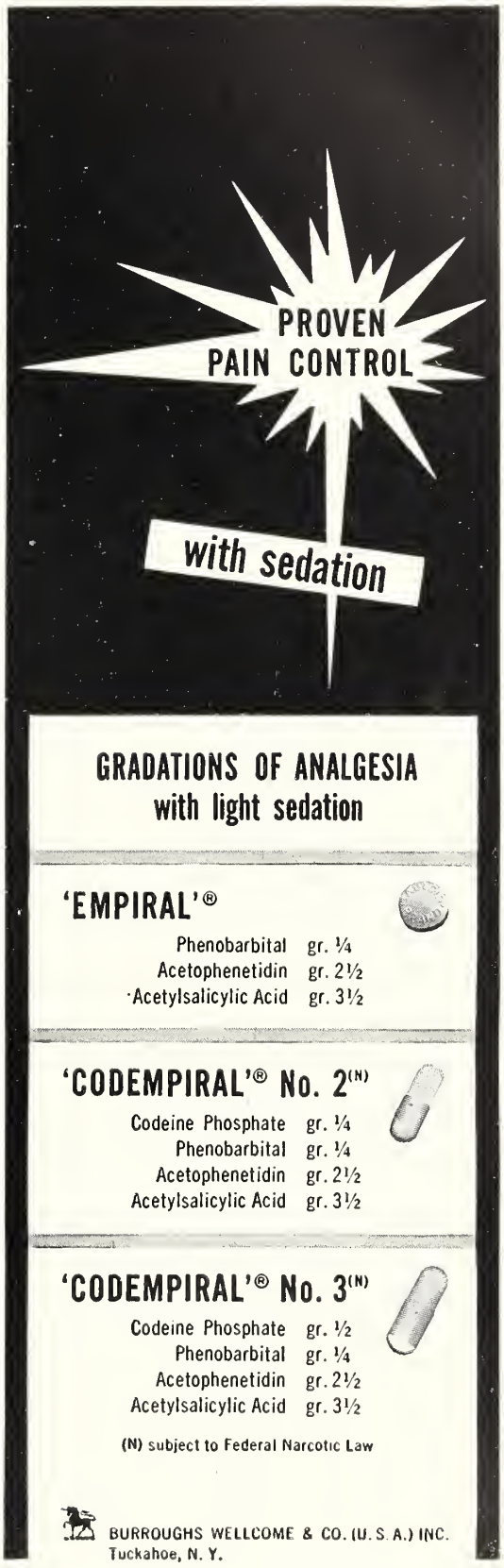
Hostesses for the meeting were Mrs. J. W. Edwards, chairman; Mrs. F. E. Spangler, Mrs. S. R. Hodsen and Mrs. J. J. Hoodlett.

HAMILTON

The annual meeting of the Woman's Auxiliary to the Hamilton County Medical Society was held on April 23 at the new Red Cross Building, 720 Sycamore Street.

Mrs. Claire Bricault, director of Heart of Home Program, spoke on "The Heart of the Home." Following the program, tea was enjoyed by members and their guest.

Mrs. Donald E. Miller and her vice-chairman Mrs. Joseph H. Goldcamp, were responsible for the gracious hospitality. Assisting as hostesses



were: Mrs. Raymond Hellman, Mrs. Harry Blaney, Mrs. John F. Mohan, and Mrs. Harry McFarland.

Results of the nominating committee were reported by Mrs. Herbert Brinker as follows: Mrs. Earl Van Horn, president-elect; Mrs. Harry K. Hines, vice-president; Mrs. William Jenning, recording secretary; Mrs. Robert Nelson, corresponding secretary. Candidates for the Board of Directors were: Mrs. Don Berning, Mrs. Eugene Fromm, Mrs. Robert Kotte, Mrs. Joseph Lindner, Mrs. Howard Pfister and Mrs. William Roach.

Committee reports were given by: Mrs. John Toepfer, civil defense; Mrs. William Lippert, Future Nurses clubs and careers in health; Mrs. Gaston Hannah, membership; Mrs. Jerome Guiseffi, telephone committee; Mrs. Robert Hawkins, Mental Health Federation; Mrs. Robert Johnstone, Public Health Federation; and Mrs. Henry Ryder, Legislation.

LUCAS

Mrs. John Dickie, Mrs. David Katchka, Mrs. Max Schnitker and Mrs. Byron Shaffer presided at the coffee tables on April 9 when the woman's Auxiliary to the Academy of Medicine of Lucas County met to hear a talk by Dr. Ralph Rabinovitch.

Dr. Rabinovitch is the director of Hawthorn Center, Northville, Mich., and spoke on "How Can We Help Our Disturbed Children?" Mrs. Richard Hotz was program chairman for the day and Mrs. Frank Fawling and Mrs. L. Reed Cranmer were chairmen for the dessert.

JEFFERSON

The Woman's Auxiliary to the Jefferson County Medical Society had its annual dinner for doctor husbands. It was a chop suey dinner held in the home of Dr. and Mrs. John Smarella on April 25. Mrs. Earl Rosenblum was in charge of the arrangements.

MAHONING

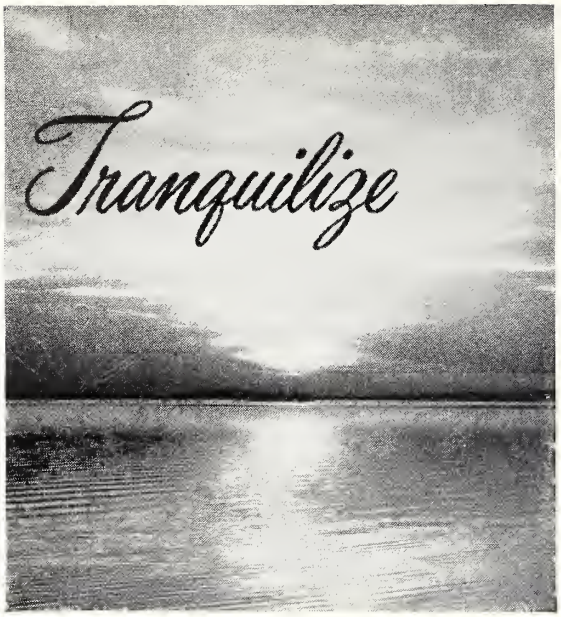
The Woman's Auxiliary to the Mahoning County Medical Society had a luncheon at the Woman's City Club, April 16. Mr. Charles Vimmerstedt spoke on the subject of safety. He is the manager of the Safety Council of Greater Youngstown.

The new officers for the following year are: President, Mrs. Cary Peabody; president-elect, Mrs. Earl Young; vice-president, Mrs. Milton Kendall; corresponding secretary, Mrs. George Altman; recording secretary, Mrs. Paul Ruth; treasurer, Mrs. A. William Geordan.

RICHLAND

Dr. C. Earl Albrecht, acting director for the State Department of Mental Hygiene and Correction, spoke to members of the Woman's Auxiliary to the Richland County Medical Society when they met at the Women's Club for a luncheon on April 1. He described the work being carried on in the field of mental hygiene by his department.

Hostesses for the luncheon were Mrs. R. Mof-



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SUMMIT

The Woman's Auxiliary to the Summit County Medical Society met for a Smorgasbord on April 1.

Dr. Oscar B. Markey, chief psychiatrist at Mt. Sinai Hospital, Cleveland, spoke on "Parents and Children Grow Together."

Mrs. W. H. Falor was named nominating chairman with Mrs. A. A. Brown, Mrs. Arthur Dobkin, Mrs. E. A. Riemenschneider and Mrs. R. A. Stahl on her committee.

TUSCARAWAS

Mrs. C. R. Crawley of New Philadelphia will serve as 1957-58 president of the Woman's Auxiliary to the Tuscarawas County Medical Society. She was elected when the Auxiliary met on April 11 at the Buckeye Hotel in Uhrichsville. Mrs. James Martin of Dover was chosen as president-elect. Other officers elected were Mrs. Pilloff, vice-president; Mrs. Paul Hahn, secretary; and Mrs. Robert Rinderknecht, treasurer.

A letter of appreciation from the supervisor of nurses at Union Hospital was read expressing the hospital's gratitude for the Auxiliary's assistance when open house was held during Nurse Recruitment Week.

A report on the Auxiliary's "Eyes for the Needy" project was given and it was deemed extremely successful.

Hostesses for the meeting included Mrs. Hammersley, Mrs. Wilson, Mrs. William Roache, Mrs. A. A. Greenlee, and Mrs. C. J. Nicosia.

New Nurse Admission Procedure Instituted at Ohio State

A new, deferred admissions procedure aimed at increasing the number who graduate from the School of Nursing at Ohio State University, received approval of Ohio State University's Board of Trustees.

Under the new program, effective the Autumn Quarter, 1957, admissions to the school will be determined at the end of the students' Freshman year in the university, rather than at the start of the Freshman year, as at present.

High school graduates interested in nursing as a career will be admitted in unlimited numbers to the College of Arts and Sciences as a Freshman. At the end of the three quarters of their Freshman year as many as possible will be admitted for the three remaining years of the nursing program on the basis of,

(1) Record made in the three quarters of preparatory work during which a cumulative point hour of at least 2.00 will be required; (2) interview with School of Nursing staff; (3) certain tests recommended by the school; and (4) health record. This will give all students a chance to prove their abilities.

Cook County
Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES—SUMMER-FALL, 1957

SURGERY—Surgical Technic, two weeks, July 15, Aug. 19. Surgery of Colon & Rectum, one week, Sept. 16; Basic Principles in General Surgery, two weeks, July 8. Surgical Anatomy & Clinical Surgery, two weeks, Sept. 30. General Surgery, two weeks, Sept. 23. Gallbladder Surgery, three days, June 24. Surgery of Hernia, three days, June 27. Treatment of Varicose Veins, Sept. 9. Fractures & Traumatic Surgery, two weeks, June 17.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Sept. 16. Vaginal Approach to Pelvic Surgery, one week, Sept. 9. General & Surgical Obstetrics, two weeks, Sept. 30.

MEDICINE—Electrocardiography & Heart Disease, two-week basic course, July 8.

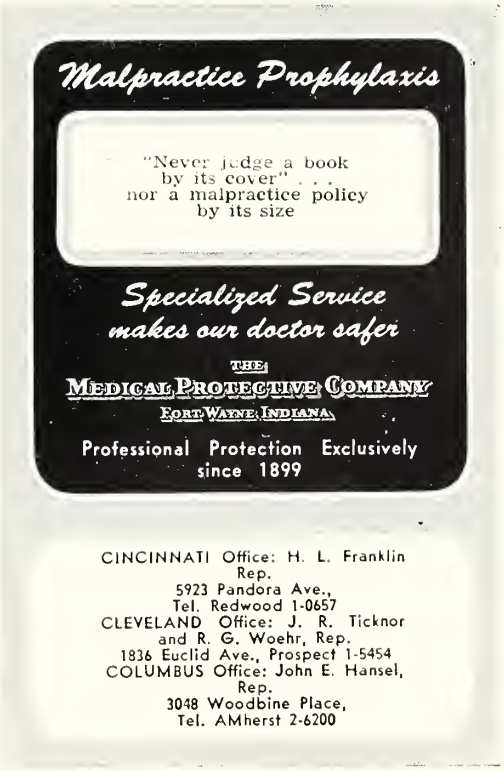
RADIOLOGY—Diagnostic X-Ray (the formal course) two weeks, Sept. 16. Diagnostic X-Ray, Clinical Course, by appointment. Radium Therapy, one week, June 24.

CYSTOSCOPY—Ten Day Practical Course by appointment.

PEDIATRICS—Neuromuscular Diseases; Cerebral Palsy, July 8.

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Ninth District Meeting and Seminar Conducted in Portsmouth

A seminar for physicians of the Ninth District was conducted in Portsmouth on April 11 under sponsorship of the Ninth District of the Ohio State Medical Association, the Portsmouth Academy of General Practice and the Southeastern Ohio Academy of General Practice. The Ninth District Woman's Auxiliary met at the same time.

"New Diagnosis and Treatment," was the theme for the program conducted by a team from the University of Cincinnati College of Medicine. Dr. Sol Asch was moderator for the seminar with the following topics and speakers:

Dr. Arnold Iglauer, associate professor of medicine, "Management of Coronary Artery Disease."

Dr. Arnold P. Graf, associate professor of obstetrics and gynecology, "Cervix Uteri in General Practice."

Dr. W. E. Lahey, associate professor of pediatrics, "The Role of Cobalt, Copper and Other Trace Elements in the Treatment of Anemias."

Dr. N. J. Giannestras, associate professor of orthopedics, "Care of Athletic Injuries."

Taking a prominent part in the meeting was Dr. Carter L. Pitcher, Councilor of the OSMA Ninth District. Mrs. William H. Evans, Youngstown, president of the Woman's Auxiliary to the OSMA, was a guest.

Mack Sauer, Leesburg editor and humorist, was speaker following the banquet. Approximately 80 persons attended.

Substantial Grant Aids Development At Western Reserve University

A grant of $500,000 from the Elisabeth Severance Prentiss Foundation to the Western Reserve University School of Medicine was announced in March. The grant, to be made at $100,000 a year, is to enable the school to meet some of its most urgent needs for future development.

According to a report in the *Cleveland Plain Dealer*, it will help make the methods of biophysics available to the various departments of the school; support the establishment of new divisions of neurology and dermatology with full-time chiefs, and give aid to the greater use of a coordinated team approach to research problems.

The newly appointed division chiefs, whose names were announced, are Dr. Clark T. Randt, associate professor of neurology, and Dr. Richard B. Stoughton, until recently assistant professor of medicine at the University of Chicago, who will be chief dermatologist. These divisions are within the Department of Medicine headed by Dr. Robert H. Ebert.

In the last two years the foundation has provided the school $232,500 for its development.

INDEX TO ADVERTISERS

Abbott Laboratories ... 625, 638-639, 713
American Cancer Society ... 724
American Medical Association ... 720
Ames Company, Inc. ... 632
Appalachian Hall ... 720
Ayerst Laboratories, Inc. ... 636 and insert between pages 636-637; 711
Baker Laboratories, Inc. ... 732
Barry Laboratories, Inc. ... 640
Burroughs, Wellcome & Co. (U.S.A.) Inc. ... 703, 714, 715, 728
California State Personnel Board ... 705
Carlson School for Cerebral Palsy ... 705
Children's Convalescent Home and Rehabilitation Center ... 699
Ciba Pharmaceutical Products, Inc. ... 726
Coca-Cola Company ... 622
Columbus Pharmacal Company ... 738
Cook County Graduate School of Medicine ... 717
Corn Products Refining Co. ... 650
Davies, Rose & Co., Ltd. ... 710
Dearborn Inn ... 707
Desitin Chemical Company ... 637
Endo Products, Inc. ... 729
Flint, Eaton & Company ... 721
Geigy Pharmaceuticals, Inc. ... 647
General Electric Co. (Prod. Eng. Dept.) ... 704
General Electric Company, X-Ray Dept. ... 727
Harding Sanitarium ... 643
Hoffmann-LaRoche, Inc. ... Insert between pages 724 - 725
Lakeside Laboratories, Inc. ... 621
Lederle Laboratories ... 682-683; 722-723; Insert between pages 732-733, 733, 734, 735
Lewal Pharmaceutical Company ... 646
Liebel-Flarsheim Co. ... 644
Lilly, Eli, and Company ... 652
Loma Linda Food Company ... 736
Mallard, Inc. ... 716
McMillen Sanitarium ... 643
Mead Johnson & Company, Pablum Products Division ... 725
Medical Protective Company ... 717
Merck Sharp & Dohme ... 628-629, 649
New York Polyclinic Medical School ... 738
Parke, Davis & Company ... 626-627, 740 and Inside back cover
Patch, E. L., Company, The ... 645
Pfizer, Chas. & Co., Inc. ... 633, 693, 697, 701, 737
Rest-Well Products Co. ... 701
Riker Laboratories, Inc. ... 709
Roerig, J. B., & Co. ... 641
Sanborn Company ... 648
Sawyer Sanatorium ... 642
Schering Corporation ... 630-631, 651
Scroggins, Clayton L., Associates (Medical-Dental Management) ... 622
Searle, G. D., & Company ... 695
Smith, Kline & French Laboratories ... 739 and back cover
Squibb, E. R., & Sons, Division of Olin-Mathieson Chemical Corporation ... 623, 731
Stoneman Press ... 730
Tutag, S. J., & Company ... 730
Wallace Laboratories ... Insert between pages 668 - 669
Wendt-Bristol Company ... 707
Windsor Hospital, Inc. ... 720
Winthrop Laboratories ... Insert between pages 644 - 645

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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GP's Define the Meaning of "General Practice"

The Congress of Delegates of the American Academy of General Practice at the recent session in St. Louis formally adopted a new definition of general practice and will urge that it also be adopted by three AMA committees now studying general practice problems. The Congress declared that "General practice is that area of medical care performed by a doctor of medicine in those fields of diagnosis and therapy commensurate with his professional competence, assuming a total continuing responsibility for the health of the individual or the family as a unit."

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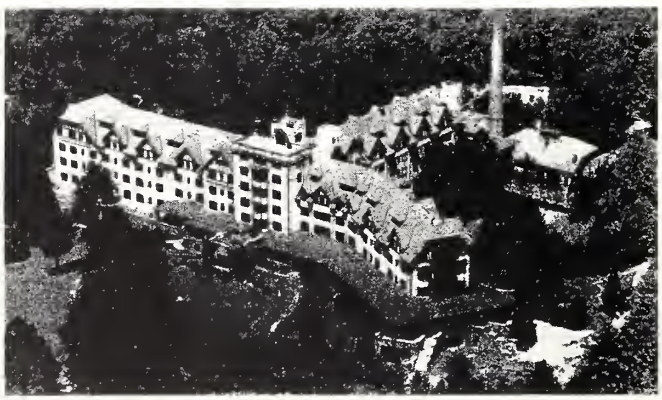
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Minor Surgery, by John E. Sutton, M. D. ($7.00. *Landsberger Medical Books Division, McGraw-Hill Book Co., New York 36, N. Y.)* This is another in the new series of handbooks for the general practitioner in the hope that it will be a guide to him in caring for surgical conditions which may easily be carried on in the office or in the patient's home without laboratory or clinical assistance.

The Clinical Care of the Diabetic, by James J. Short, M. D. ($3.95. *San Lucas Press, 316 N. Bailey St., Los Angeles 33, Calif.)* The book attempts to include sufficient background material to give a comprehensive picture of the disease as it is understood today. It omits many recent developments not relevant to its purpose. The author has turned to the moderate carbohydrate diets and assumes a middle-of-the-road attitude.

The Miracle of Royal Jelly, by Raymond Du Vois, ($2.50. *L. R. Smith & Co., Box 2003, Hartford, Connecticut.)* Much is being said nowadays about the miracle of royal jelly. Nutritionists at the University of Florida have conducted extensive experiments with this substance. The author of this book has attempted to assemble all that is known about the advantages of consuming some of this product.

Psychoanalysis Today, A Catholic Approach, by Agostino Gemelli, O. F. M., M. D. ($2.95. *P. J. Kenedy and Sons, New York 7, N. Y.)* This is a short work for the general public intended to evaluate the teachings of Freud and Jung and the various forms in which they are being presented today. Father Gemelli speaks as a psychologist, a doctor, and a psychiatrist.

Practical Neurology, by L. M. Davidoff, M. D., and Emmanuel Feiring, M. D. ($7.00. *Landsberger Medical Books Division, McGraw-Hill Book Co., New York 36, N. Y.)* This is another in the series of practical handbooks for the practicing physician. It is intended for anyone desiring a quick and reliable guide to the diseases of the nervous system which may often occur in the course of general practice, and will serve well the doctor who lacks the time to make a study of the preliminary anatomical and physiological facts.

Peptic Ulcer: Diagnosis and Treatment, by Clifford J. Barborka, M. D., and E. Clinton Texter, Jr., M. D. ($7.00. *Little Brown & Company, Boston 6, Mass.)* Here is a wise, practical handbook which collates the latest developments on this subject. The emphasis is on the patient-physician relationship. The author feels strongly that not only are the benefits of treatment greatly enhanced by the physician's ability to encourage the energetic cooperation of the patient, but also the incidence of recurrence is greatly reduced. Each chapter is in fact an independent essay on a particular facet of the problem.

The House Physician's Handbook, by C. Allan Birch, M. D. ($3.00. *E. & S. Livingston Ltd., Edinborough*, U. S. Distributor, *Williams & Wilkins Co., Baltimore 2, Md.)* This small book has been compiled to provide information about the many procedures which the house physician will have to use or know as he moves about his work. It comes from the Chase Farm Hospital at Enfield, Middlesex. The author expresses the hope that doctors in Regional Hospitals will find this book equally as useful as the others which have appeared from many teaching centers.

The Emotional Problems of Early Childhood, edited by Gerald Caplan, M. D. ($7.50. *Basic Books, Inc., 357 Bleecker St., New York, 14, N.Y.)* Under the auspices of the International Association for Child Psychiatry, 34 leading psychologists and psychiatrists here combine their experience to present the latest findings in this field.

The Epitome of the Pharmacopeia and National Formulary, issued under the supervision of the Council on Pharmacy and Chemistry of the American Medical Association. ($3.00. 10th edition. *J. B. Lippincott, Philadelphia 5, Pa.)* This book follows the general plan of the previous editions and includes the drugs currently found in U.S.P., XV and N. F., X. It gives the official title, synonyms and a brief description of the actions, uses and doses of the drugs.

Surgical Diagnosis, by Philip Thorek, M. D., with drawings by Carl T. Linden. ($12.00. *J. B. Lippincott, Philadelphia 5, Pa.)* This book is built around the method of a well-taken history, a careful evaluation of the symptom complex, a properly conducted physical examination, and the consideration of the pertinent laboratory data. It is all done in clean-cut, easily understandable arrangement. The illustrations add much to the text.

Christopher's Textbook of Surgery, edited by Loyal Davis, M. D. ($15.50. 6th edition. *W. B. Saunders Co., Philadelphia, Pa.)* In the 20 years since the first edition of this book appeared, it has gained a place as a text without equal. Under Dr. Davis's skillful handling the material has been brought up to date, to serve as a teaching tool.

Current Therapy, 1956, edited by Howard F. Conn, M. D. ($11.00. *W. B. Saunders Co., Philadelphia 5, Pa.)* This volume continues the excel-

lent practice of recording the personal methods of treating a specific disease by well-known men. The book therefore has an individuality and a value above most of the books intended to keep one up to date in therapeutics.

The Doctors Mayo, by Helen Clapesattle. ($0.50. Cardinal Giant Book. *Pocket Books Inc., New York, N. Y.)* The history of the well-known surgeons is here presented in pocketbook form. It is a reprint of the book published by the University of Minnesota in 1941.

Practice in Radiotherapy, by Sir Ernest Rock Carling. ($20.00. *Butterworth & Co., Ltd., London;* United States distributor, *C. V. Mosby Co., St. Louis, Mo.)* This book is designed to expand the presentation of a specialized subject, and provide a picture of radiotherapeutic practice today. The preliminary articles deal with some of the general problems and then the book goes into details of treatment of individual patients with different problems.

Diseases of the Liver, edited by Leon Sehiff, M. D., with the collaboration of 27 contributors. ($16.00. *J. B. Lippincott Co., Philadelphia 5, Pa.)* The complexity of the liver's countless functions and the array of differing clinical manifestations in liver disease make this book of help to every practitioner. The entire range of liver disease is considered thoroughly from both clinical and pathological standpoints. The material is presented in such a way as to lend itself to the use of the internist and the general practitioner, and at the same time be helpful to the surgeon and the specialist.

Diseases of the Chest, by H. Corwin Hinshaw and L. Henry Garland. ($15.00. 634 illustrations. *W. B. Saunders Company, Philadelphia, Pa.)* This volume has been prepared by professors of medicine and radiology at Stanford University, in an effort to keep pace with the rapid developments in this field and to provide an up-to-date textbook for students and practitioners, adequately illustrated to encompass most of the disorders of the chest which are likely to be encountered in practice. It is sufficiently terse to permit a ready grasp of present-day methods of diagnosis and treatment.

Mental Disorders in Later Life, edited by Oscar J. Kaplan. ($7.50. 2nd edition. *Stanford University Press, Stanford, California.)* It has been 10 years since the first edition appeared. The field of gerontology has grown immensely since then. Activity and progress have not been uniform in the various areas represented in this book. Some chapters have been entirely re-written, others revised, and others stand about where they did 10 years ago. Although the mental disorders of later life remain unconquered, they are no longer regarded as invincible. Of particular interest to your reviewer is the excellent chapter by Clyde McKay on Food For the Later Years.

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Vol. 53 July, 1957 No. 7

JONATHAN FORMAN, M. D., *Editor*

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Diffuse Interstitial Fibrosis Complicating Rheumatoid Arthritis

Report of a Case

WARREN W. SMITH, M. D., and NORMAN O. ROTHERMICH, M. D.

SINCE 1948 there have been reported[1-7] about a score of patients with rheumatoid arthritis who also exhibited pulmonary infiltration of various types. Histologic study of the lungs was possible in many of these patients, and disclosed either (a) diffuse interstitial pneumonitis indistinguishable from that described by Hamman and Rich,[8] (b) granulomatous lesions, many of which were morphologically similar to the rheumatoid nodule, or (c) coarse pulmonary fibrosis. In these cases, the pulmonary lesions were apparently permanent. On the other hand, two patients with rheumatoid arthritis have been reported[2,3] who exhibited transient peribronchovascular infiltration which appeared with exacerbation of the arthritis and then disappeared completely with subsidence of the joint symptoms. No histologic studies were available in these patients.

This communication reports another patient with rheumatoid arthritis complicated by pulmonary fibrosis of type indistinguishable from that described by Hamman and Rich.

REPORT OF CASE

In April 1949, when this white office worker was 51 years old, a routine chest x-ray (Fig. 1) disclosed slight increase in hilar and bronchovascular markings. In 1951, the patient underwent cholecystectomy which was complicated by postoperative bronchopneumonia with complete recovery.

Later in 1951 patient developed polyarthritis involving the feet, ankles, knees, shoulder girdle, elbows and fingers. The clinical syndrome was typical of rheumatoid arthritis. He was treated with salicylates with moderate but incomplete relief.

Early in March 1954, the patient developed coryza, sore throat, and dry cough, followed the next day by malaise and left pleuritic pain. Mild exertional dyspnea was first noted about this time. He was admitted to the Ohio State University Hospital on March 13, 1954, at which time he was first seen by us in consultation.

Physical examination disclosed blood pressure 140/80 mm. Hg; temperature 99° F.; pulse 75 per minute, regular; respirations 25 per minute. The patient was noted to be a husky, mesomorphic middle-aged man who exhibited occasional dry cough but who otherwise did not appear ill. There

Submitted August 20, 1956.

The Authors

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● Dr. Rothermich, Columbus, is Physician in Chief, Columbus Medical Center; member of the staffs of University, Mt. Carmel, and White Cross Hospitals; Associate Professor of Medicine and Head of the Arthritis Division in the Department of Medicine, Ohio State University College of Medicine.

was moderate increase of the anteroposterior diameter of the chest. There were fine rales in the lower halves of both lung fields, more prominent on the right. The heart size was clinically indeterminate; the rhythm was regular, and there were no murmurs. The sounds at the base were about equal. The left knee was swollen, and there was moderate limitation of flexion of the right elbow, and mild swelling of left elbow and

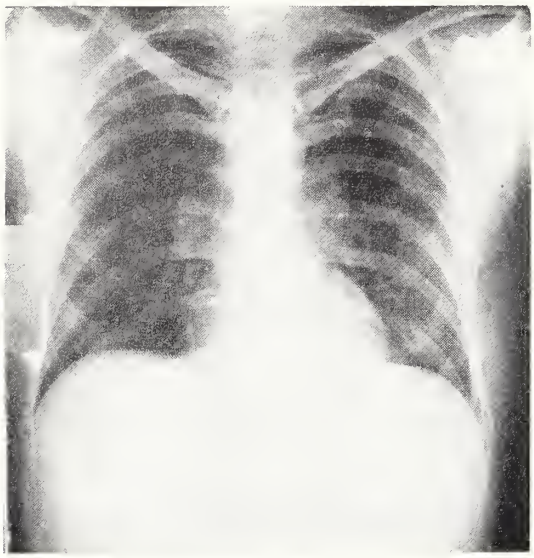


Fig. 1. For Explanation, See Text.

dorsum of the right wrist. There was no other edema. One observer considered that there was clubbing of the fingers of the left hand, with cyanosis of the nailbeds.

Laboratory: Red blood cell count 5.9 million; hemoglobin 16.0 Gm. per 100 cc., white blood cells 17,750 with a normal differential. Urinalysis was negative save for the presence of a very few white and red blood cells. The erythrocyte sedimentation rate was only 8.5 mm. per hour (Wintrobe, corrected). Serum uric acid 3.2 mg. per 100 cc.; fasting blood sugar 89 mg.; prothrombin time 90 per cent; serologic test for syphilis negative; serum albumin 4.2 Gm. per 100 cc.; globulin 2.1 Gm. Culture of the sputum disclosed predominantly Neisseria with some *alpha-* and *beta-* hemolytic Streptococci, Pneumococci, and Hemophilus. Two acid-fast smears were negative, as were two sputum cultures for M. Tuberculosis.

Chest x-ray (Fig. 2) disclosed pleural effusion bilaterally, more on the right, with extensive reticular infiltrations throughout both lung fields. These were more marked in the right than the left lung, and were more dense in the lower portions of both lungs. There were several areas of patchy consolidation. There was hilar adenopathy. The heart was not well visualized.

The patient was treated with sedatives, salicylates, phenylbutazone, and meperidine as needed for pain. Thoracotomy was done and a specimen for biopsy was taken from the right lower lobe of the lung. Microscopic examination* (Fig. 3) disclosed marked thickening of the alveolar septa, with distortion and collapse of the alveoli. Most of the alveoli contained exudate consisting of chronic inflammatory cells and macrophages. Similar exudate was also seen into the smaller bronchial lumina. There was chronic inflammatory reaction and fibrosis of the interstitial tissue with numerous foci of lymphoid tissue. In some areas there was proliferation of the interstitial tissue with a papillary appearance, lined by cuboidal to low columnar epithelial cells. The pathological diagnosis was "chronic interstitial pneumonitis with fibrosis" — indistinguishable from that described by Hamman and Rich.[21]

The patient was discharged from the hospital on March 31, on corticotropin gel 80 units thrice weekly, and oral hydrocortisone 20 mg. thrice daily. On this regimen the arthritic compaints subsided considerably and the cough diminished. There persisted mild exertional dyspnea. During

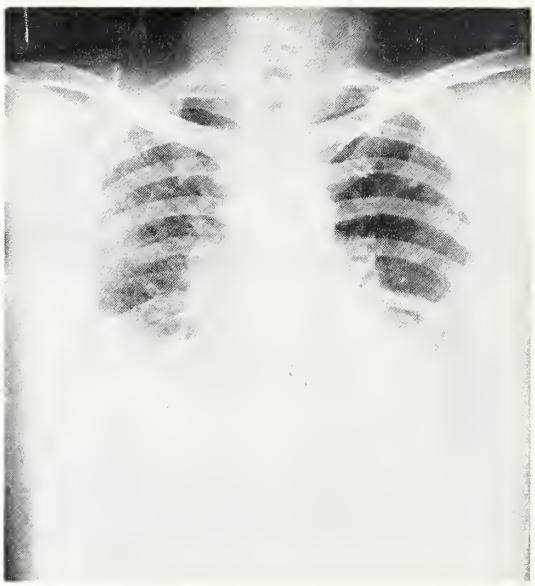


Fig. 2. For Explanation, See Text.

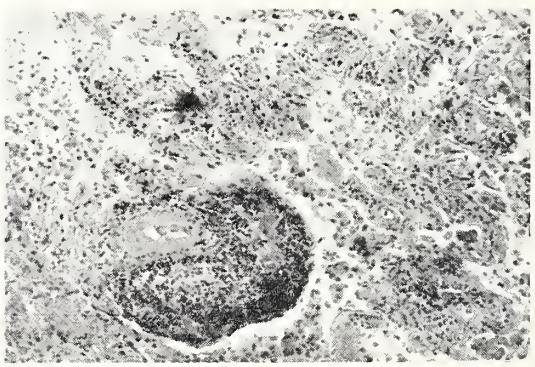


Fig. 3. For Explanation, See Text.

the next two months the density of the pulmonary infiltration appeared to lessen slightly. The patches of consolidation cleared, leaving the widespread reticular infiltration little changed. During the following nine months the pleural effusion subsided entirely.

From May, 1954, through the winter of 1955, the patient had occasional episodes of bilateral pleuritic pain, each lasting three or four days. Because of the progressive severity of the arthritic symptoms, and increasing cough, the dosage of steroids was gradually increased to 150 mg.

*The authors are indebted to Dr. Emmerich von Haam, Professor of Pathology at Ohio State University, for kindly reviewing these sections.

of cortisone a day plus corticotropin gel 80 units about three times a week.

On March 3, 1955, because of the gradual development of edema of the face and the lower extremities, the patient was rehospitalized and was again seen by us in consultation. Physical examination at that time disclosed blood pressure 110/60 mm. Hg; temperature 99.2°F.; respirations 22 per minute. The patient was in no acute distress. Wheezes and rales were noted bilaterally in the lung bases. There was percussion flatness bilaterally at the bases, but breath sounds were present. There was minimal clubbing of the fingers. There was slight periorbital edema and slight pedal edema. The left knee was warm, slightly swollen and painful on motion.

Laboratory: Red blood cell count 5.3 million; hemoglobin 16 Gm. per 100 cc.; white blood cell count 12,800 with a normal differential. The erythrocyte sedimentation rate was 21 mm. per hour (Wintrobe corrected). Urinalysis was negative; prothrombin time 70 per cent; fasting blood sugar 105 mg. per 100 cc.; serologic test for syphilis negative; serum albumin 4.8 Gm. per 100 cc., globulin 2.9 Gm. The electrocardiogram was within normal limits.

Chest x-ray taken during that hospitalization disclosed no significant difference from the film taken in March 1954, except for the disappearance of the right pleural effusion and of the patchy areas of consolidation. The cardiac silhouette was again not well visualized because of the overlying pulmonary infiltration.

It was concluded that the patient's edema was due to the high dosage of adrenal steroids, and he was treated with a salt-free diet, reduction of corticotropin to 20 units a day and of cortisone to 100 mg. a day. There was diminution of edema, and the patient was discharged after several days.

From Spring of 1955 to March 1956, the patient did fairly well. He missed practically no time from work because of his illness. He had moderate stiffness of certain joints (chiefly in upper extremities) with typical jelling phenomenon. There was mild exertional dyspnea with moderate dry cough. When he was reevaluated at the Columbus Medical Center by the authors in March 1956, he was on a regimen of prednisone 10 mg. a day, 80 units of corticotropin gel five times a week, 60 to 80 grains of acetylsalicylic acid a day, pyribenzamine® 200 mg. a day, and occasional supplements of vitamin C.

Physical examination at that time disclosed a heavy-set white male who did not appear ill. There was a definite increase of anteroposterior diameter of the chest, and respiratory excursions were slightly reduced, but symmetrical. Resonance was normal. There were many crepitant inspiratory rales in the lower halves of both lung fields. The point of maximal cardiac impulse was not palpable. The rhythm was regular at 90 per minute and the heart sounds were of good quality. The pulmonic second sound was louder than the aortic second sound. The peripheral arterial pulses were readily palpable. There was a trace of pretibial edema. There was questionable clubbing of all fingers, and minimal but definite cyanosis of lips and nailbeds. The only objective evidence of arthritis was swelling and incomplete extensibility of the proximal interphalangeal joints of the third and fourth fingers on the left.

Cardiac fluoroscopy was unsatisfactory because of the thickness of the chest wall and the pulmonary infiltration. There was no conspicuous cardiac enlargement. Chest x-ray (Fig. 4) disclosed little change from the film taken two years before. Other laboratory studies disclosed: Red blood cell count 5.0 million; hemoglobin 15.3 Gm. per 100 cc.; white blood cell count 13,700, with a normal differential. Hematocrit was 50 per cent. Erythrocyte sedimentation rate was 19 mm. per hour (Wintrobe, corrected). Urinalysis, total serum protein, serum protein electrophoresis, were normal. Serologic test for syphilis, and lupus erythematosus cell preparation were negative. The vital capacity was 2.2 liters in three seconds (42 per cent of predicted normal).

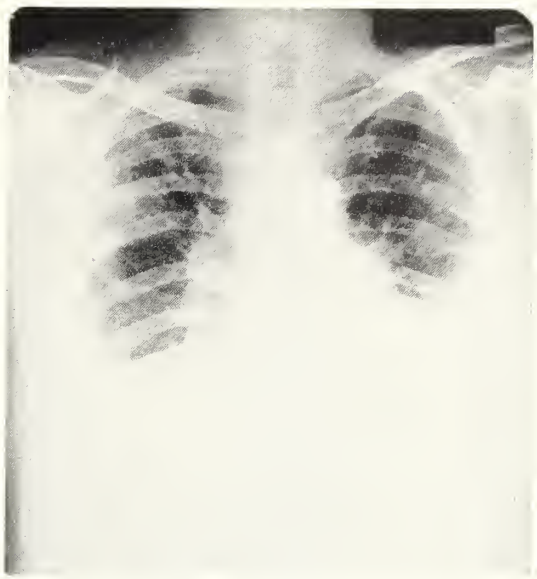


Fig. 4. For Explanation, See Text.

SUMMARY OF CASE

This middle-aged male developed typical rheumatoid arthritis in 1951, and three years later noted onset of cough and exertional dyspnea. Chest x-ray at that time revealed widespread pulmonary infiltration with pleural effusion. Lung biopsy disclosed a histologic picture of interstitial pneumonitis indistinguishable from that of Hamman and Rich. With very intensive adrenal hormone therapy, the patient's arthritis and pulmonary symptoms have improved greatly. Except for the development of pulmonary hypertension, his condition has clinically remained stationary for the two years after detection of pulmonary complications.

DISCUSSION

The lesions of rheumatoid arthritis are seen in many tissues and organs, but characteristically involve the mesenchymal tissue.[9] They are not specific, but may be simulated in certain other diseases, particularly the group which are currently referred to as the "collagen" diseases. The most characteristic focal lesion is the formation of granulation tissue (which may encroach upon nearby normal tissue with subsequent fibrosis), the accumulation of collagen, "fibrinoid degeneration," and infiltration with a variable number of

mononuclear leukocytes. Lesions of this type are most commonly seen in serous and synovial membranes, subcutaneous tissue, skeletal muscle, and in close proximity to nerves; but have also been found in myocardium, kidney, lung and other organs.[4]

Although the rheumatoid nodule is *clinically* encountered most often in subcutaneous tissue, histologically identical lesions may be found elsewhere in the body. Occasionally they may occur in lung and may grow to enormous size: one of Christie's[5] autopsied cases had a subpleural nodule which was 7 centimeters in diameter.

The authors have found reports[1,7] of five patients who were considered to have rheumatoid arthritis in whom chronic fibrosing interstitial pneumonitis was also found on roentgenographic and histologic study; two additional patients have been described[1,7] with similar clinical and roentgenographic findings but no tissue studies. Because in many of these patients the pulmonary and the arthritic components varied commensurately in severity, it was considered that the pulmonary disease was a part of the rheumatoid arthritis, or, more precisely, "rheumatoid disease."

Clinically there was observed a parallel between the severity of the pulmonary and arthritic symptoms. The chief pulmonary symptoms were dry cough and exertional dyspnea. Physical examination always disclosed many fine rales, usually concentrated in the lower halves of the lung fields. Cyanosis and circulatory congestion were commonly seen. The chest x-ray disclosed reticular infiltration throughout both lung fields which often was most dense just above the diaphragm. Pleural effusion was often present. Most of the patients responded well symptomatically to induced hyperadrenalism, although the objective pulmonary lesions changed little if at all. There was a marked tendency to the development of cor pulmonale, which was often the cause of death. In some of the reported cases, patients died within several months of recognition of pulmonary disease—others were alive at the time of reporting, a year or so later.

The question naturally arises, whether these patients with the rheumatoid arthritis syndrome complicated by the type of pulmonary infiltration just described are in fact true examples of rheumatoid arthritis or "rheumatoid disease." This question cannot be answered because of our present ignorance of the fundamental nature of rheumatoid arthritis. Interstitial pulmonary fibrosis has been reported in patients who were considered to have systemic lupus erythematosus,[10] dermatomyositis,[11] scleroderma,[12] and periarteritis nodosa.[13] The probable close relationship of the fundamental derangement in rheumatoid arthritis to that in these diseases has been debated for years[7,13-17] and will not be reviewed here. It does appear, however, that in patients with rheumatoid arthritis, neither the severity nor the duration of the disease—measured in terms of the arthritis—is exclusively the basis for the development of this type of pulmonary complication: a review of 120 cases of rheumatoid arthritis seen in the Columbus Medical Center between January 1, 1956, and June 1, 1956, confirms this observation.

SUMMARY

This is a report of a patient with rheumatoid arthritis complicated by interstitial pneumonitis with fibrosis indistinguishable from that described by Hamman and Rich. Reference is made to the few other similar cases in the literature, as well as to other forms of pulmonary infiltration which have been observed in patients with clinical rheumatoid arthritis.

Acknowledgment: Our thanks are due to Dr. Walter Stout, the patient's personal physician, for his kind cooperation. Figure 1 is a reproduction of an x-ray made in Dr. Stout's office.

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Serum Prothrombin Consumption Test For Diagnosing Quinidine Allergy

The serum prothrombin consumption test decreases the risk of hemorrhagic side effects from quinidine therapy for cardiac arrhythmias. It detects abnormalities in the thromboplastin complex, even before they are apparent in the platelet count.—Gittler, R. D.: Kissin, M., and Litwins, J.: *Ann. Int. Med.*, 42:1118, May, 1955.

Overenthusiasm in the Treatment of the Elderly Patient in Congestive Failure

M. H. ROSENBLUM, M.D.

THE elderly patient with congestive failure who is put to bed and given the therapeutic "works" may early become a subject of a protocol in the pathology department. The overzealous physician who desires to quickly relieve his patient of congestive failure may find that the clinical course of the patient is not a smooth and happy one.

Thewlis has emphasized that overtreatment in the aged results in a high mortality rate. The conventional regimen of putting the patient to bed, full doses of opiates, rapid digitalization, high concentration of oxygen, mercurial diuretics, ammonium chloride, excessive sodium restriction in the diet, applied to an aged person may not be the best plan of treatment. Particularly in mild congestive failure must the physician be on guard not to overtreat. Pepper stated that many old people have lived with their maladies for many years and they have become more or less adjusted to them. He felt it would be unwise to abruptly disturb this so-called "symbiotic state." In a high percentage of elderly patients, more than one pathologic process contributes to their disability; especially pulmonary disease may be a co-existing ailment. The delicate balance of an occult renal insufficiency may be disturbed by an electrolyte imbalance resulting from the energetic use of the mercurials.

Each ingredient of the cardinal prescription in the management of congestive failure may be the source of trouble if not used in proper and therapeutic doses for that patient. The ingredients in this prescription of rest, digitalis, oxygen, mercurial diuretics, ammonium chloride, restricted sodium in the diet, and sometimes opiates must be compounded with care and wisdom.

REST

This does not mean being confined entirely to bed. Fundamentally, rest is an important therapeutic principle in the treatment of congestive failure. The patient may use a bedside commode or even go to the toilet if he desires to do so and if it is close by. He may spend some of the time sitting in a comfortable arm chair which is not too low and so constructed that there is no pressure in the popliteal areas. When the patient is in bed, it is advisable to see that the bedcovers do not restrict free movement of the feet. This is particularly important at night to obviate thrombosis of veins of the lower extremities which in turn may lead to serious or fatal pulmonary emboli.

Strict bed confinement may mechanically cause a shifting of tissue fluid from lower parts to upper parts of the body with a possible aggravation of pulmonary congestion. There is a real hazard of thrombophlebitis with its serious complications as already mentioned in complete bed confinement.

DIGITALIS

Congestive failure resulting from impaired myocardial function from defective muscle contraction calls for the use of digitalis. It is the most important drug in its management. One, however, should not only be acquainted with its therapeutic use but also with its toxic effects. There has been no improvement made in the description of the toxic effects of digitalis since Withering in 1785. He wrote, "The Foxglove when given in very large and quickly repeated doses occasions sickness, vomiting, purging, giddiness, confused vision, objects appearing green or yellow, increased secretion of urine with frequent motions to part with it and sometimes inability to retain it, slow pulse even as slow as 35 in a minute, cold sweats, convulsions, syncope, death."

The elderly patient may have a limited therapeutic range for digitalis and toxicity may be manifest at lower dosage levels. The call for rapid digitalization in congestive failure in the aged is rare. A more gradual adjustment in the dynamics of the circulation is advantageous.

Digitalis and its glycosides have produced every known type of arrhythmia and conduction defect. King[1] has described six cases of delirium which occurred in association with digitalis therapy. In each case, the disturbance cleared entirely on withdrawing the drug. Headache, neuralgias of the face and upper extremities have been observed as a manifestation of digitalis toxicity. The aged person may complain of weakness, lassitude, insomnia, and irritability as a toxic manifestation. Increasing congestive failure occasionally may be

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a result of overdosage with digitalis. Evidence of minor toxicities should be heeded to prevent major cardiotoxicity which may lead to a lethal consequence.

Some deficiency in potassium commonly occurs in congestive failure.[2] Therapeutic procedures relative to the treatment of congestive failure may further increase the potassium deficit. Studies have shown that digitalis will produce toxicity at a lower dosage level in the presence of low potassium and that the duration of toxicity is extended.[2] It has been suggested that increased sensitivity to digitalis may result from alterations in the intracellular potassium distribution rather than changes in the serum potassium.

In regard to the choice of the digitalis preparation, it would be well to continue to use the same type of preparation if the elderly patient is receiving benefit from it and the dosage tolerance is known. If the patient has not been on digitalis the physician may use the whole leaf or the glycoside with which he is most familiar. Rapid intravenous digitalization should be avoided unless the demand for speed is clear-cut.

The danger of intravenous digitalis should not be accepted in the aged unless the situation is so critical that it would be unsafe to permit several hours to pass in order to gain the therapeutic effect of oral digitalis. If the patient's condition is critical, as in severe pulmonary edema with very rapid heart action (and it is clear that the tachycardia is not a cardiotoxic effect of previously administered digitalis), lanatoside C may then be administered intravenously. Half a digitalizing dose is given in a 5 minute period and if necessary, repeating the dose by half as much in each of two hourly periods. When the emergency has passed, digitalis should be given orally and at a slower rate.

OXYGEN

Rest and digitalis alone may be sufficient to produce diuresis, relieve dyspnea and improve the patient's cardiac status. Many times, however, oxygen is an important modality in congestive failure management. When used in therapeutic dosage it is indeed beneficial and tides the patient over a critical period. However, placing the aged patient in an oxygen tent and being unaware of some of the consequences may add complications to the management or may even be a factor in hastening death of the patient.

In the first place, many elderly patients are frightened when enclosed in an oxygen tent. If oxygen therapy is necessary the patient should be reassured when placed in the tent or better still, a mask or nasal catheter should be used.

The aged patient is less likely to tolerate inhalation of oxygen in high concentration because of possible co-existing pulmonary disease as, for example, emphysema. The physician may be unaware of the existence of emphysema as the physical findings in the chest may be overshadowed by signs of congestive failure and the appearance on the roentgenogram may be inconspicious or obscured by other chest findings. On the other hand, one should be on guard not to confuse a condition which is primarily due to a failing lung rather than a failing heart.

In the patient with pulmonary emphysema there is an abnormally high tension of CO_2 in the alveolar air. A high tolerance is developed towards the CO_2 and the respiratory center loses its exquisite sensitivity towards it. In the administration of oxygen, the severely emphysematous patient hypoventilates with further increases of the $_PCO_2$. The arterial oxygen saturation may be maintained near normal by the continued administration of the oxygen; however, the CO_2 removal is interfered with by the inadequate ventilation or by interference of the transfer of gases in the lung. This situation may result in mental disturbance ranging from confusion, mania, or drowsiness to profound coma and death.

There may be associated headache, muscle twitching, increased intracranial pressure, and occasionally papilledema. The cause of the mental changes during oxygen inhalation is uncertain. Several possible mechanisms have been offered as an explanation. They are[3]: (1) CO_2 narcosis, (2) cerebral vasospasm, (3) reflex depression of the cerebral cortex by the high oxygen tension, (4) increase in cerebrospinal fluid pressure, (5) direct depression of the cerebral cortex by the high oxygen tension.

Barach feels that coma resulting from oxygen therapy in patients with pre-existing chronic anoxia is preventable. He explains that respiratory acidosis takes place in patients who are given high concentration of oxygen suddenly and there isn't time enough for the patient to excrete chloride. Controlled administration of gradually increased concentration of oxygen does not result in either delirium or coma. His method is to use the nasal catheter in patients of this type at an oxygen flow of 1 liter per minute and increased every other day by 1 liter per minute until 7 liters per minute is used. After that 40 to 50 per cent oxygen may be used in a tent if desired. The gradual increase in the concentration of oxygen inhaled results in gradual increase of the CO_2 in the blood. There is a correspondingly higher elimination of CO_2 per breath. There is also an increased elimination of chloride with retention of base and the avoidance of respiratory acidosis.

MERCURIAL DIURETICS

In recent years, mercurial diuretics have been used with abandon in congestive failure. The intravenous use of mercurials have given way to intramuscular and subcutaneous injections. The latter routes of treatment have made it easier for nurses and even for patients themselves to administer the mercurials. It is conceivable

that the elderly patient may enter the hospital in so-called "intractable congestive failure" with an electrolyte imbalance due to injudicious use of the mercurials; and more mercurial diuretics be given by an unsuspecting and enthusiastic physician with dire results to the patient. Even when the patient has been under the continuous care of an able and experienced physician, symptoms of electrolyte depletion have been overlooked with irreversible reaction and death taking place.

An editorial in a recent edition of the *British Medical Journal*[4] stressed that the overenthusiastic use of mercurial diuretics, especially in conjunction with a diet very low in sodium, may result in disaster. Grace E. Bergner and coworkers[5] reported three patients who received the conventional therapy for heart failure, regained compensation, but died within a few days without apparent cause. Anorexia, lethargy, and eventually stupor preceded the death of each. Analysis of their records and clinical course suggested that an electrolyte imbalance had been precipitated during treatment of the cardiac failure.

Limited renal function as may occur in the elderly patient should, of course, make the physician more cautious in the use of mercurial diuretics. Newburgh[6] demonstrated that low sodium diets add a further burden on damaged renal tubules when diuretics are used.

Although excessive mercurial diuresis may cause sodium depletion, it is believed that the "low salt syndrome" following excessive diuresis is actually cases of hypochloremia with alkalosis. These patients may have normal serum sodium concentration. However, a lowered serum sodium may follow the hypochloremia or accompany it. A decrease in the concentration of serum potassium may occur along with the sodium depletion. As previously mentioned, a low potassium concentration may increase the likelihood of digitalis intoxication.[2]

With the loss of electrolytes resulting in increased impairment of kidney function and particularly in the aged who already may have diminished kidney reserve, the nonprotein nitrogen of the blood rises.

At times to potentiate the action of mercurial diuretics ammonium chloride is given. In the presence of renal disease and the impairment of normal base conserving mechanism the excretion of sodium may be excessive. Not infrequently the continued use of ammonium chloride may lead to retention of chloride with ultimate "chloride acidosis."

At this point, it is well to emphasize George C. Griffith's statement, "Edema in the peripheral tissues is not a danger to the patient which calls for immediate removal by drastic, even heroic, measures. The 'drying out' process should occupy an extended period of time rather than hazard the safety of the patient and only after adequate rest and digitalization has been evaluated." This particularly applies to the management of edema in the elderly patient.

OPIATES

At times it may be necessary to administer narcotics to elderly patients. It is well to remember that old and debilitated patients are more sensitive to the depressant actions of morphine and the dose should be correspondingly reduced. The morphine acts directly on the respiratory center and the effect may be discernible even with small doses insufficient to produce sleep or disturb consciousness. One should particularly be cautious in the use of morphine in patients with hypoventilation in whom oxygen is being administered. Under these circumstances, the narcotic effect of morphine may be superimposed upon the so-called "narcotic effect" of the high CO_2 concentration.

Meperidine (demerol®) has become a popular narcotic agent in recent years and has been used often in place of morphine. The former drug has somewhat lesser depressant action on respiration than morphine but it still should be used with caution in the elderly anoxemic patient.

SUMMARY

(1) It is hazardous to give the elderly patient all we have to offer for his congestive failure in gunshot dose fashion.

(2) Each modality of treatment should be used with care and circumspection.

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Diamox in Edema Of Pregnancy

Diamox® is a potent drug to increase sodium excretion in those patients who are potentially toxic. That this increased excretion is significant is demonstrated by the controlled series reported.

A convenient way to evaluate the sodium retention of the potentially toxic gravid patient is described as a 48 hour diamox® test. The patient is instructed to restrict sodium intake; then she is weighed, given diamox® on three consecutive mornings and weighed again after 48 hours. A loss in weight of 2 per cent of the total body weight is indication that further diamox® therapy is justified.—Edward Balthrop, M. D., and J. Melvin Young, M. D., Pensacola: *J. Florida M. A.* 43:1201-1203, June, 1957.

Unusual Case of Long-Standing Aneurysm Of the Thoracic Aorta

JACK T. COLLINS, M.D., and SALVATORE M. SANCETTA, M.D.

ANEURYSMS of the thoracic aorta are either saccular or fusiform. Whereas the great majority of the saccular ones are due to syphilis, fusiform enlargements constitute a less well-defined entity. These may be either true aneurysmal dilatations, or may represent healed dissecting aneurysms. Regardless of etiology, all are likely to demonstrate progressive enlargement when observed over a period of years.

The following instance of an asymptomatic fusiform aortic root aneurysm in a Negro laborer now aged 46 years is reported because of failure to enlarge during eight years' observation. There is evidence that it has been present for at least 20 years. The etiology is undetermined.

REPORT OF CASE

The patient, a Negro laborer, now aged 46 years, was hospitalized on the Medical Service of Cleveland City Hospital in 1947 because of trichinosis. Abnormal physical findings consisted of temperature elevation, muscle tenderness, an abnormally palpable suprasternal pulsation, and a faint blowing holosystolic murmur heard only over the second right parasternal area. The blood pressure, on several determinations, did not exceed 124/76. A routine teleoroentgenogram of the chest showed an aneurysmal dilatation of the aorta (Fig. 1).

The patient denied having had syphilis, and the blood and spinal fluid serologic tests were negative. A film of the pelvic region did not demonstrate old bismuth deposits. On further questioning, the patient stated that 12 years previously, at age 25, a chest film was taken in Logan, West Virginia, because of a non-productive cough lasting one month. At that time he was told that "the tube leading from his heart was enlarged." The blood Wassermann test was said to have been negative.

The patient convalesced uneventfully from trichinosis and was discharged.

He was seen in 1954 and again in 1955 at the request of his wife, a hospital employee, only because she had been told that the patient ought to have periodic check ups. On his most recent visit, in June of 1955, he was working at heavy labor and was totally asymptomatic except for a complaint of recent epigastric distress. This was shown to be due to a radiologically proven duodenal ulcer which has responded satisfactorily to therapy.

On physical examination he appeared as a well nourished, heavy set and muscular man. The temperature was 37.5 degrees C., respiratory rate was 14, and the heart rate 64. The blood pressure was now 160/100. The pupils were normal, and the fundi showed Grade I vascular changes, as against normal findings eight years previously. There was still an abnormal suprasternal pulsation. The heart was not enlarged to percussion. There was a faint, blowing systolic murmur over the second right parasternal area. The aortic closure sound was accentuated but not tambouric, and was louder than the pulmonic second sound. The remainder of the examination revealed normal findings. A 12 lead electrocardiogram was likewise normal.

Cardiac fluoroscopy demonstrated no definite change in the appearance of the aorta, although it was now thought that there was borderline enlargement of the left ventricle (Fig. 2).

Communication with Logan General Hospital, Logan, West Virginia, bore the following information: "Mr. ..... was seen in the outpatient department of this hospital on December 13, 1935, with chief complaint of cough of a month's duration. No hemoptysis. Appetite very good. Weight 170 pounds with average weight 180 pounds. No chest pain. He had been working all the time.

"On examination the chest was negative. Blood pressure 130/80. Heart showed a soft aortic systolic murmur. Dilated aorta suggestive of aneurysm by 7 foot x-ray plate. Kahn test reported as negative. He returned on December 18, 1935. Blood pressure 132/80 in both arms. Feeling better. Working. Inasmuch as our x-rays are kept only five years, we do not have the chest film available which was taken at that time. He was admitted to the hospital on June 15, 1944, and discharged June 21, 1944, with history of injury in a mine accident. Blood pressure 128/80. Final diagnosis: Fracture of third lumbar transverse process."

DISCUSSION

The various causes of thoracic aortic aneurysms may be grouped as follows:

Saccular
- Syphilitic.
- Mycotic.
- Traumatic.

Fusiform or diffuse
- Syphilitic.
- Arteriosclerotic - hypertensive (including coarctation of the aorta).
- Acute or healed dissecting aneurysm.
- Traumatic.

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From the Department of Medicine, Western Reserve University School of Medicine at City Hospital, Cleveland.
Submitted June 4, 1956.

Congenital weakness of the media and/or elastic lamellae (Marfan's syndrome).

? Rheumatic fever.

Syphilis as an etiologic agent in this case may be dismissed because of the repeatedly negative blood and spinal fluid serologies, early onset of the aneurysm (at least since age 25), and the failure progressively to enlarge over a known period of eight years in the absence of specific therapy. This would be most unusual, even had antiluetic therapy been administered, inasmuch as the weakening of the aortic media, incident to destruction of the elastic components, cannot be reversed. The presence of a diffuse, rather than a saccular enlargement, without calcification in the ascending aorta, reenforces this argument.

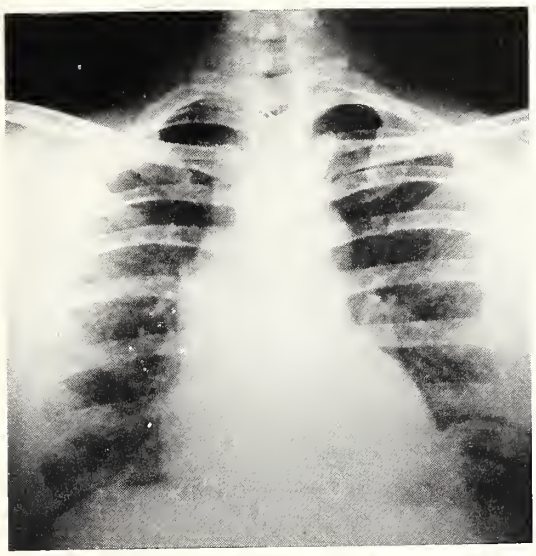


Fig. 1. Teleoroentgenogram of chest, taken in April, 1947.

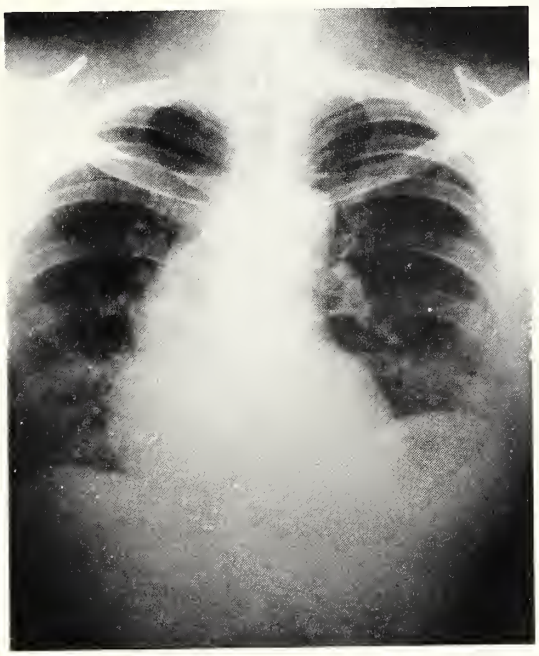


Fig. 2. Same, taken in June, 1955. The patient is slightly rotated from the standard PA projection. Careful fluoroscopy failed to show definite difference in appearance of the aorta from the films already on record.

There is no history of trauma. When the latter is the initiating factor, there has usually been a severe crushing injury of the chest, and serial chest films are likely to reveal rather rapid increase in size of the resulting aneurysm.[2] It may be parenthetically mentioned that on occasion trauma may aggravate an already existent aortic wall weakness with the development of an aneurysm at the site.[6]

Arteriosclerosis, usually in association with hypertension, represents today the most common cause of fusiform aortic ectasia. Maniglia and Gregory analyzed 6000 autopsies during the years 1903-1952. They pointed out that whereas syphilis represented the more common cause in the early years covered by the study, the more prevalent etiology in later years had shifted to arteriosclerosis and hypertension.

This patient now demonstrates evidence of asymptomatic, chronic "benign" hypertension, but it is most unlikely that this should have been operative as a cause for the past 20 years. This would hardly be in keeping with the natural history of the disease. In addition, random blood pressure determinations 20, 11, and 8 years ago were well within normal limits.

Chronic healed dissecting aneurysm also does not appear to be a likely possibility. The overwhelming majority occur in hypertensive patients above the age of 45 years, are usually ushered in by severe pain, and when healed are almost invariably accompanied by aortic insufficiency.[1]

Although a reasonably rare entity, Marfan's syndrome was considered. The subject of this report failed to show other stigma of this interesting complex: The trunk and limbs were normal, there was no syndactylism, and slit lamp examination failed to show a lenticular dislocation. Given the heritability of Marfan's syndrome,[5] a searching inquiry was made of the blood relatives, and although none were available for examination, no suggestive history of this disease was obtained.

The last remaining possible cause is an old, healed rheumatic aortitis. After several years of study, Pappenheimer concluded that whereas rheumatic aortitis may be a real entity, it does not lead to aneurysm formation. There have been at least two reports of aortic aneurysm of presumed rheumatic origin,[3,4] but neither case was confirmed by pathologic evidence.

In summary, the etiology of the aneurysmal aortic dilatation in this subject is unknown. If one should wish to speculate, it would appear that an abortive, albeit unproved instance of the dystrophic aortic changes said to be operative in Marfan's syndrome is the most likely possibility.

The interesting feature in this case is the existence of the aortic dilatation, with no proven etiology, for 20 years without evidence of pro-

gression. The beguiling feature lies in the assumption that, had no previous evidence relevant to the blood pressure and recorded chest films been available, what with the negative serologies and the moderate hypertension now present, the case would have readily been pigeon-holed as a common instance of aortic ectasia due to arteriosclerosis and hypertension.

SUMMARY

We have reported the somewhat unusual case of an asymptomatic laborer now aged 46 years, who has a fusiform aneurysm of the root of the aorta. This has shown no progression during eight years of personal observation, it has probably been present since at least age 25, and is of unknown etiology.

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Seven Thousand Insect Pests Are Injurious to U. S. Crops

One of the longest and toughest wars on record is the struggle for survival between the human race and the insect population of the world.

At the present time the box-score on this war indicates no better than a stalemate. This is serious, since one of the main offensive actions of the insect world is directed toward destroying our food supply. Our defense against food destroying insects is costly and time-consuming, and involves much careful work and planning, because the chemicals which we use against the insect pests are harmful to humans if improperly used, or if the foods are excessively contaminated by them.

As good as the American diet is, it is still short of ideal, and to mention one item, it should contain more of vitamins A and C. These vitamins are produced in crops which cannot be raised without the help of pesticides.

Of the more than 80,000 insect pests in the United States, about 7,000 are injurious to crops. Over 80 high vitamin crops require the use of agricultural chemicals for successful production. —EDITORIAL: Pesticides and Safety, *J. Indiana State M. A.*, 50:581, May, 1957.

Mumps Meningoencephalitis

Mumps meningoencephalitis is probably the most common cause of the syndrome of "aseptic meningitis." The diagnosis of mumps as the cause for such a central nervous system condition is based on a number of criteria, of which the presence of parotitis or history of exposure to mumps would be the most significant. It should be strongly emphasized, however, that a very substantial proportion of persons undergoing infection with mumps virus will have no signs of salivary gland involvement. Furthermore, it has been demonstrated serologically that a significant proportion of cases of "aseptic meningitis," in the absence of parotid or salivary gland involvement, are, in fact, due to mumps virus. The small proportion in the present series of cases in which there was no parotid involvement does not reflect the true proportion of such cases, but rather reflects the factors leading to admission to the hospital.

The clinical findings in cases of mumps meningoencephalitis often will suggest the proper etiological diagnosis. In most cases, meningismus subsides rapidly along with the fever, over the course of two or three days. This is in contrast to poliomyelitis, in which the stiffness of neck or back may become more severe after the temperature has subsided. The absence of any weakness would certainly raise the question of mumps as an etiologic possibility. In sévere cases of mumps meningoencephalitis in which coma and lethargy and high fever are prominent symptoms, a variety of other viral encephalitides will remain prominent in the differential diagnosis.

One of the most commonly encountered situations in which the differential diagnosis should be satisfactorily resolved is that of the patient for whom the diagnosis of poliomyelitis with clinically inapparent paralysis is considered. If mumps can be diagnosed as the cause, then all the long term considerations attendant upon the diagnosis of poliomyelitis may be dismissed. On the other hand, if proof of mumps is not forthcoming, long term follow-up with careful examinations to detect the appearance of muscle weakness will be necessary. The economic implications of this situation would seem obvious.

It is often necessary for the physician to depend upon serological studies to establish the diagnosis of mumps meningoencephalitis. Such laboratory studies should be given early consideration and appropriate blood specimens should be submitted to the laboratory. In a case where viral encephalitis is considered a likely cause for the clinical condition, an early or "acute" blood specimen should be obtained and stored for possible future use for serological comparison with a later or "convalescent" specimen.—Henry B. Bruyn, M. D., et al., San Francisco: *California Medicine*, 86:153, March, 1957.

Studies on the Etiology and Specific Treatment Of Multiple Sclerosis

EDWARD C. ROSENOW, M.D.

IN extended studies on the causation of diverse diseases, including multiple sclerosis, it was found that specifically virulent nonhemolytic streptococci could be readily separated from saprophytic types usually also present in the nasopharynxes of persons having chronic disease. This was done by making serial dilution cultures of nasopharyngeal swabbings in tall columns of dextrose-brain broth in test tubes at dilutions of 10^{-2}, 10^{-6} and 10^{-10}, and making subcultures from the end points of growth of such cultures.

Streptococci thus isolated and injected intravenously into rabbits and white mice localized electively in the brains and spinal cords of the animals.[1-3] Periods of exacerbation of multiple sclerosis occurred in varying degrees and incidence in each of the 56 white persons studied. Twenty-six were males and 30 were females. The ages ranged from 26 to 72 years. Nystagmus, intention tremor, ataxia, slurring speech, exaggerated reflexes in involved extremities, weakness and undue hopefulness characteristic of the disease were noted in varying degrees and incidence.

METHODS OF STUDY

Diagnostic skin tests for specific circulating streptococcic antigen were made by injection into the skin of the forearm, 0.05 ml. of thermal antibody solutions in the supernatant of NaCl solution suspensions containing 20 billion streptococci per milliliter that had been isolated in studies of multiple sclerosis, autoclaved for 96 hours and diluted with equal parts of NaCl solution plus 0.2 per cent phenol. As a control measure, streptococcic antibody was injected that had been similarly prepared from streptococci isolated in studies of other diseases.

Skin tests for circulating streptococcic antibody were made by injecting 0.05 ml. of the supernatant of NaCl solution suspensions containing 2 billion streptococci per milliliter that had been heated at 70°C. for 1 hour.[4] Specific streptococcic thermal antibody for therapeutic use and agglutination studies also was made from NaCl solution suspensions containing 10 billion streptococci per milliliter to which 1.5 per cent hydrogen peroxide from a 30 per cent solution was added, autoclaved for three hours and brought to *p*H 7.0. Streptococcic antibody solutions made with and without hydrogen peroxide were injected subcutaneously in comparable dosage in treatment.

After degree of erythematous reaction had been noted at the point of injection and the clinical effects of the administration of varying dosages of both vaccine and thermal antibody solutions had been assessed, the following schedule of skin tests and of dosage was used routinely:

One-tenth milliliter of the autogenous or stock vaccine containing 200,000,000 streptococci per milliliter isolated from the nasopharynxes of persons who had multiple sclerosis was injected subcutaneously for the first injection. This dose was increased by 0.1 ml. twice weekly up to the amount of 1 ml. Then 1 ml. was injected each week for an indefinite period, provided local and constitutional reactions were minimal and provided favorable clinical effects occurred.

One-half milliliter of the stock or autogenous multiple sclerosis thermal streptococcic antibody from 10 billion streptococci per milliliter was injected separately subcutaneously, but at the same time or more often, if favorable results ensued. This dose was increased to 2 ml. and was given twice weekly or daily, provided local reactions at the point of injection were minimal or negative and provided clinical results were favorable.

Erythematous reaction at the point of injection of vaccine and antibody, and clinical results were used as guides for increments or diminutions of doses. Since such injections were harmless and had to be repeated over long periods, some member of the family or a nurse was instructed to give the injections. Local reactions to repeated injections usually diminished, in respect to both vaccine and antibody, as clinical improvement occurred.

RESULTS

Cutaneous reactions to the intradermal injection of antigen and of thermal antibody in per-

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Submitted July 7, 1956.

The Author

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TABLE I.—ERYTHEMATOUS CUTANEOUS REACTIONS (SQ. CM.) IN PERSONS HAVING MULTIPLE SCLEROSIS TO THE INTRADERMAL INJECTION OF THERMAL ANTIBODY-INDICATING ANTIGEN AND OF ANTIGEN-INDICATING ANTIBODY PREPARED RESPECTIVELY FROM STREPTOCOCCI ISOLATED FROM THE NASOPHARYNXES OF PERSONS WHO HAD MULTIPLE SCLEROSIS, NEUROSES AND ARTHRITIS.

Persons who had multiple sclerosis	Cases	Reactions in square centimeters to intradermal injection of streptococcic				
		Antigen-indicating antibody			Antibody-indicating antigen	
		Multiple sclerosis			Neurosis	Arthritis
		8125*		7700*	8126*	8134*
Not receiving vaccine or thermal antibody	23 20	5.75 6.25	7.31 8.07	9.63	3.14 5.04	1.43 2.15
Receiving streptococcic antibody and vaccine	13	7.86	3.15		3.85	1.86

*Stains of streptococci or case numbers.

sons who had multiple sclerosis are summarized in table 1. It will be seen that the immediate erythematous reactions to the intradermal injection of streptococcic antibody (taken to indicate specific circulating streptococcic antigen in patients not receiving antibody or vaccine therapeutically) were far greater (7.31, 8.07, and 9.63 sq. cm.), respectively, than in persons receiving therapeutic injections of antibody and vaccine (3.15 sq. cm.).

Cutaneous erythematous reactions indicating antibody (5.75 and 6.25 sq. cm.) were significantly less in persons not receiving such therapeutic injections than in persons receiving such treatment (7.86 sq. cm.). Erythematous reactions following intradermal injection of control antibody solutions were uniformly minimal, but in each of the three groups having multiple sclerosis reactions were greater to injections of "neurotropic" (8126) streptococcic thermal antibody than to corresponding injections of "arthrotropic" (8134) antibody prepared respectively from streptococci isolated in studies of diseases of the nervous system and arthritis.

In an additional group of 11 persons who had multiple sclerosis, not included in table 1, the average erythematous cutaneous reaction indicating specific circulating streptococcic antigen was 9.3 sq. cm. before therapeutic injections of thermal antibody, 5.82 sq. cm. the day after the first therapeutic injections of antibody, and 3.3 sq. cm. the day after the second such treatment. In sharp contrast, cutaneous reactions indicating circulating streptococcic antibody increased in size as follows: 3.78 sq. cm. after the first; 5.83 sq. cm. after the second; and 6.65 sq. cm. after the third therapeutic injection of antibody. Clinical improvement occurred in parallel with (1) the diminutions in reactions indicating specific circulating streptococcic antigen as (2) reactions indicating circulating antibody increased.

Evidence indicating specificity of the streptococcus isolated in studies of multiple sclerosis is indicated also by the respective agglutinative titers of thermal antibody solutions prepared from the streptococcus with and without hydrogen peroxide. Thus, the agglutination titer of "antibody" prepared by autoclaving NaCl solution suspensions containing 20 billion streptococci per milliliter for 96 hours without hydrogen peroxide at four tenfold dilutions of 1-10 to 1-10,000 was 65 per cent for the autogenous streptococci isolated in studies of multiple sclerosis; for streptococci isolated respectively in studies of respiratory infection, 0 per cent; schizophrenia, 19 per cent; epilepsy, 19 per cent; coronary heart disease, 44 per cent; hypertension, 50 per cent; and poliomyelitis, 50 per cent.

Moreover, the agglutinative titer of thermal antibody prepared from NaCl solution suspensions containing 10 billion streptococci per milliliter from dense glycerol-saturated NaCl solution of respective suspensions, autoclaved for but three hours after the addition of 1.5 per cent hydrogen peroxide, was equally specific. Thus, the average agglutinative titer of thermal antibody at four tenfold dilutions of 1-10 to 1-10,000 prepared from a composite suspension containing 10 strains of streptococci isolated from the nasopharynxes of persons having multiple sclerosis was 94 per cent; for streptococci similarly isolated in studies of lymphatic leukemia, 38 per cent; for carcinoma, 31 per cent; experimental poliomyelitis, 63 per cent; epidemic poliomyelitis, 56 per cent; respiratory infection, 38 per cent; schizophophrenia, 19 per cent; epilepsy, 25 per cent; and coronary heart disease, 31 per cent.

Clinical response to the subcutaneous therapeutic injection of heterologous streptococcic vaccine and thermal antibody solutions, while favorable, was usually not as great nor as constant as it was to the autogenous preparations. In both instances there was diminution in cutaneous reactions in repeat tests indicating specific circulating streptococcic antigen, and an increase in reactions indicating circulating antibody as symptoms abated.

In persons who had multiple sclerosis associated with undue pain indicating an associated neuritis in the affected extremities, vaccine and thermal antibody prepared from the streptococcus isolated in studies of multiple sclerosis usually did not suffice to control the pain and progress of the disease, whereas the use of autogenous

vaccine and thermal antibody in such cases usually did suffice to effect such objectives. Return of symptoms in previously affected regions and erythematous reactions to repeated intradermal injections of specific antibody, indicating specific circulating streptococcic antigen, occurred in three patients several months after specific treatment with vaccine and antibody had been discontinued. The symptoms and positive reactions indicating specific circulating streptococcic antigen in each of the three patients disappeared when treatment with specific vaccine and thermal antibody was resumed.

SUMMARY AND CONCLUSIONS

Results of a bacteriologic and immunologic study on the causation and specific treatment of multiple sclerosis are reported.

Evidence has been adduced to indicate that this strange, persistent, progressive, chronic disease is caused by a specific type of nonhemolytic neurotropic streptococcic infection or intoxication.

The evidence indicates that such peculiar affinity of the streptococcus in multiple sclerosis for the nervous system is acquired in the nasopharynxes of persons stricken with the disease, and that the disease is not caused by streptococci from extraneous sources, such as milk, water supplies or respired air. Results of specific treatment by means of the subcutaneous injection of specific streptococcic vaccine have been favorable, but the best results have been obtained from the separate injection of both specific streptococcic vaccine and thermal antibody. Such treatment, although specific and effective, needs to be continued indefinitely to prevent recurrence.

In this as in other studies, the ability to isolate specific types of nonhemolytic streptococci from nasopharyngeal swabbings in diverse diseases and from other materials is due (1) to the use of dextrose-brain broth in tall columns in test tubes, which affords a gradient of oxygen tension and other conditions highly favorable for the growth of fastidious organisms, (2) to the selection of pure cultures of the streptococci from the end points of growth of serial dilution cultures in this medium, and (3) to the preservation of viability at 10°C. for some months and antigenic specificity for years in dense suspensions of 2 parts of glycerol and 1 part of saturated NaCl solution.

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KEEPING UP WITH MEDICINE

• IT IS PROBABLE that the amelioration of hypokalemic alkalosis despite the simultaneous administration of sodium by cortisone results from the capacity of this hormone to break down tissues, thus releasing potassium which is then available to replenish the deficiency in the intact cells.

* * *

• ALTHOUGH skin testing and the Blatt-Nantz Test for bacterial sensitization are accepted by all allergists as worthwhile, there can be no doubt that bacterial sensitization and bacterial infection without sensitization play an important part in asthma in children and that the judicious use of antibiotics and bacterial filtrates or vaccines is often followed by good results.

* * *

• PROTEIN is certainly central in the prophylactic and therapeutic measures connected with experimetal and clinical hepatic injury. It, however, in itself does not necessarily represent the complete answer. With the exception of severe acute necrosis and decompensatic chronic phases of cirrhosis, protein or lipotropic substances are beneficial.

* * *

• BIG BABIES are said to retain a weight advantage for at least two years.

* * *

• DURING the premenstrual phase in normal women, there is retention of water, sodium and chloride. This is reflected in gain in weight of from three to ten pounds and there may be recognizable generalized edema.

* * *

• THE PRESENT-DAY treatment of Fibrocystic Disease of the Pancreas consists of high caloric, protein and vitamin with low-fat diet; pancreatic products; detergents to increase digestion and absorption; antibiotic to reduce and control pulmonary infection. The objective is to keep down the lung involvement.

* * *

• THE GREATEST height gains of a child and the smallest weight gains occur in the sunny months.

* * *

• MOST of the states in which renal retention of sodium is prominent are associated with either diminution of total blood volume or a sequestration of blood in peripheral veins.

* * *

• VITAMIN K deficiency occurs in normal newborn infants for the first one or two days until the proper intestinal flora can be established to produce this vitamin.

* * *

• DISEASE PROCESSES influence the flow of urine by imposing restrictions or excesses in relation to the excretion through the influence of the antidiuretic hormone (ADH), a presumed-independent mechanism for renal - tubular - reabsorption of water, or the excretion of solutes.—J. F.

Tuberculosis and Pregnancy*

DAVID T. KAUNG, M. D.

THERE is rather general agreement that pregnancy exerts neither a beneficial nor a deleterious effect on tuberculosis. In the minds of some, however, there is still disagreement. The reason for conflicting opinions stems from the failure to recognize the following facts:

1. Tuberculosis is a chronic and relapsing disease. The slow evolution of the disease makes attempts to relate cause and effect extremely difficult. With the passage of time, some cases will improve and others deteriorate.

2. The prognosis and course of a case of tuberculosis depend on numerous factors, the most important of which are: extent of disease, activity of disease, and adequacy of care.

Any claim of effect of pregnancy on tuberculosis should be based on the demonstration of an effect which exceeds the natural variation in the course of tuberculosis. Relationship of pregnancy to survival rates many years after the event may seem significant statistically, but certainly ignores the complexity of life and its influence on tuberculosis. On the other hand, total disregard for statistical methods and complete dependence on experience gathered from a few selected patients can only lead to unreliable impressions.

EFFECT OF PREGNANCY ON TUBERCULOSIS

All the available studies involving relatively large numbers of individuals, and with some attempts at control of factors such as those mentioned above, have failed to demonstrate any significant effect of pregnancy on the course of tuberculosis. Undoubtedly cases which show deterioration during and shortly following pregnancy do occur and are well remembered. One does not need to look far, however, before a similar non-pregnant case is found. The claim that the gravid uterus favorably influences the course of tuberculosis, and the sudden descent of the diaphragm following delivery adversely influences it, is equally difficult to substantiate.

Physiological changes during pregnancy also fail to render support in either direction. The elevation of the diaphragm and the decrease of the residual volume of the lungs produce some physiological rest. However, the increased excursion of the diaphragm, the increased tidal volume (average 39 per cent), increased oxygen consumption (average 32 per cent), and the increased basal metabolic rate (23 per cent) all point to increased work and reduced rest.

*This is one of a series of articles on chest diseases sponsored by the Ohio Trudeau Society, medical section of the Ohio Tuberculosis and Health Association.

Submitted April 17, 1957.

The Author

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INDICATIONS FOR THERAPEUTIC ABORTION

If one accepts the majority opinion that pregnancy does not influence the course of tuberculosis, there is obviously no indication for therapeutic abortion at any time. Reported series comparing the results of aborted and nonaborted groups have shown no significant difference. These series, however, are all selected to a greater or lesser extent, depending on the criteria used for abortion. It is likely that the more serious cases are interrupted, thus adversely weighing the outcome of this group. In practice about an equal number of such cases are not aborted simply because they are seen too late for safe abortion.

With the advancement in the medical and surgical care of the tuberculous patient, one is faced occasionally with a patient who has extremely low respiratory capacity and who has become pregnant. The increased burden of pregnancy would seem certain to throw the patient into cardiorespiratory failure. However, studies by Gaensler et al. show that these patients have successfully undergone pregnancy and delivery. It is not possible at present to draw any arbitrary line concerning the minimal functional reserve required for pregnancy and delivery. Close consultation between the chest physician, the pulmonary physiologist, the cardiologist, and the obstetrician will be necessary to reach a good clinical decision regarding therapeutic abortion.

Little is known regarding the effect of pregnancy on extrapulmonary tuberculosis. Again, clinical judgment will have to suffice.

INDICATIONS FOR PREVENTION OF PREGNANCY

It is generally agreed that it is safe for patients with inactive disease to undergo pregnancy. However, most tuberculosis physicians advise against pregnancy during the active phase of tuberculosis. If one pursues the conclusion that pregnancy does not influence tuberculosis, one is hardly justified in advising against pregnancy at any time. One must remember, however, that the burden of child rearing and other socio-economic

factors do influence the course of tuberculosis. Cohen et al., indeed, found that more tuberculous activity was demonstrated in the years not associated with pregnancy than during pregnancy and the year immediately thereafter, in 149 mothers followed 5 to 20 years. The indication for prevention of pregnancy is therefore socio-economic.

EFFECT OF TUBERCULOSIS ON PREGNANCY

Genital tuberculosis accounts for a small percentage of female infertility. However, pregnancy usually proceeds without complication. The early concern for fetal damage through maternal transfer of chemotherapeutic agents has not been substantiated. Congenital tuberculosis is a rarity.

CONCLUSION

Pregnancy does not influence the natural course of tuberculosis. Severe cardiorespiratory deficiency due to tuberculosis may be an indication for therapeutic abortion. Prevention of pregnancy is often desirable on a socio-economic basis.

Evaluation of Drug Treatment Of Hypertension

The newer antihypertensive drugs are impressive in their ability to lower blood pressure, to alter the course of severe and malignant hypertensive disease, and to combat arteritis and congestive heart failure. There is no convincing evidence that any drug or combination of drugs is of great value in the mild hypertensive patient, although they may lower blood pressure over long periods of time. In malignant hypertensive patients these drugs give more predictable results than has any previous type of treatment, and in the absence of uremia can be expected to improve the course of the disease.

There are major objections to the use of these drugs. Many of them have undesirable side effects closely allied to the mechanism by which they lower blood pressure. Others have frequently associated toxic effects which at times may endanger the patients.

Likewise, these drugs must be very carefully controlled, and most of them must be given in divided doses over 24 hours. None of them, so far as we know, actually treats the cause of essential hypertension. Their considerable cost is a factor that limits their usefulness. They do not have any direct effect on the companion problem of arteriosclerosis, which will probably become increasingly important in these patients as some of the acute effects of their high blood pressure disappear.

Until definite information has been gained concerning the etiology, classification and life history of hypertensive disease, management of these patients must of necessity be imperfect.—Walter M. Kirkendall, M. D., Iowa City: *J. Iowa M. Soc.*, 47:300-305, June, 1957.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Gorge—The classical Latin name for the throat was "guttur" and from this came the Latin word "gargulio," or windpipe. This word then developed into the Late Latin word "gorga," or throat. This word was at first applied to the throat and then to the whole neck and later to things shaped like a neck or throat, such as a "gorge" or ravine. Hence also "to stuff the throat with food or to 'gorge' oneself." The word came into English via the French.

Glycyrrhiza—Also known as "licorice," this popular cough remedy and vehicle for cough mixtures comes from the dried roots of a perennial herb growing in Southern Europe and Western Asia. The name "glycyrrhiza" literally means "sweet root" and is derived from the Greek words "glykys," or sweet, plus "rhiza," or root.

Tumour—The Latin word "tumor" means a swelling, and the term was applied by the ancients to any swelling of unknown cause and origin. The term has continued in constant use up until present times, but its meaning is now restricted to new growths such as cancers, sarcomas, etc.

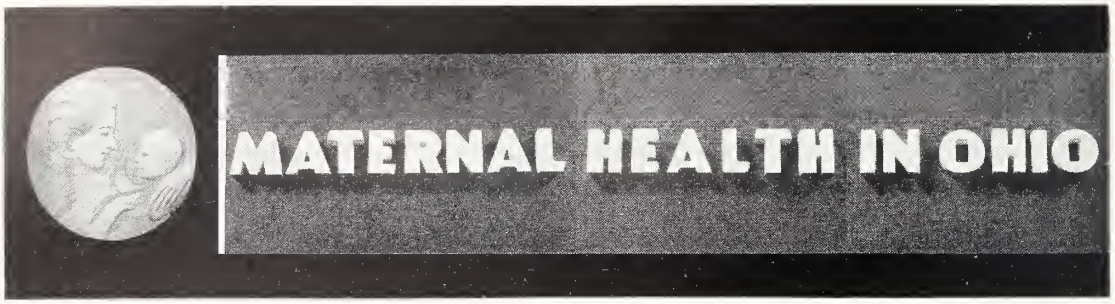
Trochanter—A Greek word meaning a runner, which is derived from the Greek words "trechein," to run, and "trochos," or wheel. The ancient Greeks and also Galen originally applied this term to the rounded head of the femur, because it turns in its socket like a wheel. In later usage the term became transferred in meaning, so that it now designates the two bony eminences just below the neck of the femur which are respectively called the greater and lesser trochanters. These were probably so called because of the part they play in the rotatory movements of the thigh.

Triquetrum—This is the third carpal bone from the radial side in the proximal row, which was formerly called the cuneiform bone. It was so named because of its triangular shape, the Latin word "triquetrus" meaning three cornered.

Trigeminal Nerve—The word "trigeminal" means triplets and is composed of the Latin words "tres" or three, plus "geminus," a twin. The trigeminal nerve was described by Fallopius in the sixteenth century and was at first called the trifacial nerve. However, Jacques Benigne Winslow, a Dutch anatomist, re-named it the trigeminal nerve in his anatomical text which was published in 1732.

Tricuspid Valve—The term tricuspid is applied to structures having three points or cusps and is composed of the Latin words "tres" or three, plus "cuspis," a point. The tricuspid valve of the heart was described and named by Erasistratus who lived from 310 to 250 B. C.

—Harry Wain, M. D., Mansfield, Ohio.



A CONTINUOUS state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and assisted by official representatives of the various County Medical Societies of the state.

Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, will be published in *The Ohio State Medical Journal* from time to time. Each presentation will be brief but informative. It will contain opinions of the Committee, based on the data submitted for review. In the series of cases, entitled "Other Causes," the three cases in this eleventh report have to do with maternal death due to afibrinogenemia.

CASE NO. 42

The patient was a 35 year old, Negro, Para III (one set twins) who died six and one-half hours postpartum. Her past history was not remarkable; two previous pregnancies were delivered at term (one a set of twins) without complication. Prenatal care adequate, course uneventful. Although the last menstrual period was of uncertain date, her estimated date of confinement was set for August 15.

At 8:15 p. m. on June 27 (about 32 weeks gestation), she was admitted with membranes ruptured and "pains all day." Examination revealed *no fetal heart sounds*, a fundus "approximately 7 month size," rather soft uterus with 3 minute contractions, no vaginal bleeding, (Rectal) Station –3, 2 cm. dilatation, 50 per cent effaced, and blood pressure 139/86. Demerol® and scopolamine were administered; at full dilatation, diagnosis of breech presentation was made noting absence of meconium. Spinal anesthetic (50 mg. procaine) was administered followed by a sharp fall in blood pressure (80/40).

By breech extraction a stillborn fetus was delivered at 11:58 p. m. over an episiotomy. In 5 to 10 minutes the placenta was expressed (Crede) and revealed a coagulated "clot over the whole area." Profuse uterine bleeding occurred with *atony;* the fundus was "wiped out," oxytoxics were administered *but* bleeding continued (estimated 8,000 cc.). During repair of the episiotomy, an *absence* of clot formation was noted.

Eight grams of fibrinogen was given to the patient, along with whole blood. The patient continued to bleed and remained in shock. Clamps were "placed vaginally on cervical arteries to control bleeding" without much effect. The patient pursued a downhill course and died June 28. No laboratory data were available. Autopsy permission was obtained.

Cause of death: Afibrinogenemia, placental separation, seventh month pregnancy, premature rupture of membranes.

Pathological diagnosis: Postpartum uterus; rupture of uterine cervix; hemorrhage of uterine cervix; retroperitoneal hemorrhage; hemorrhagic ascites; subendocardial hemorrhage.

COMMENT

This case apparently falls into the category of the "dead fetus syndrome" and "abruptio" placenta. From facts in the case these were accidental complications. The Committee questioned indications surrounding the elective use of a spinal anesthesia in this breech delivery of a dead fetus. It appears that post-spinal hypotension was followed in turn by breech extraction, expression of placenta with pathognomonic clot, massive hemorrhage *with persistent uterine atony* and visible defect in blood-clotting mechanism. Details of measures to prevent or combat the initial hypotension were not reported. The Committee voted this a preventable death.

CASE NO. 131

This patient was a 26 year old, white, Para V who died two hours postpartum. Her past history revealed an oophorectomy five years before, and four vaginal deliveries (three at term, one premature) without complication; two were alive and two died of causes not reported. Her last period was May 18; prenatal care was considered adequate and uncomplicated. On February 25 (at term) the patient passed some clots and was admitted to the hospital. Examination by a consultant revealed the cervix thickened on the left, with diagnosis of low-lying placenta. He advised rupture of membranes at 4 cm.; this was done 24 hours after spontaneous labor started, revealing thick, greenish-yellow amniotic fluid. At 5:40 a. m. on February 26 a lethargic fetus was delivered spontaneously using open drop ether. The baby died in spite of attempts to

resuscitate it. The placenta was delivered by Crede method with moderate hemorrhage.

After she was returned to her bed, the patient had a sudden severe uterine hemorrhage (about 6:25 p. m.). She was treated with oxytoxics and whole blood, through cut-downs which were necessitated due to collapsed veins. The blood observed had "lost the property of clotting"; fibrinogen was administered in an amount between 1 and 2 grams. Oxygen was administered. The uterus was manually compressed. All measures failed to reduce the massive exsanguination, and the patient died at 7:50 p. m. Laboratory studies were not reported. Permission for autopsy was obtained.

Cause of death: Postpartum hemorrhage, uncontrollable due to afibrinogenemia; sudden collapse.

Pathological Diagnosis: Fibrinogenopenia with acute hemorrhage; status postpartum; active pancarditis, rheumatic (?).

COMMENT

The Committee voted this case a nonpreventable death. It was noted that laboratory studies were not available; toward this end a question was raised concerning the empirical use of ready "O-Neg" blood without crossmatching, all of which would have been justified in such a dire emergency. Conversely, if blood had been withdrawn from the patient for testing, absence of a clot formation might have given an earlier clue to the diagnosis. In view of the consultant's diagnosis, the Committee was curious to know the general appearance of the placenta.

CASE NO. 144

This patient was a 42 year old, white, Para IV, abortus II, who died an hour or so postoperative. Past history was not remarkable; four term pregnancies were delivered without complication. Details concerning previous abortions were not available. With a last menstrual period October 23, the patient visited her physician on January 10, and again March 16. The last visit she complained of vaginal bleeding for a week; examination revealed a uterus smaller than 20 weeks gestation, and the Friedman test was *negative*. A consultant, finding particles of degenerated placental tissue in the cervix made a diagnosis of missed abortion.

On March 20 a dilatation and curettage was performed, removing a large amount of necrotic placental tissue and degenerated pieces of fetus. It was noted that the patient (for some unknown reason) took her anesthetic poorly. In the recovery room vaginal bleeding was "more than usual"; the patient was returned to the operating room where the uterus was explored. The uterus was relaxed but no tissue was obtained; a pack was placed in the uterine cavity, but blood oozed through the pack. Vaginal hysterectomy was performed quickly, and a large amount of blood issued from the posterior cul-de-sac. The uterus showed no sign of perforation. Despite the surgery, the patient seemed to bleed from every surface, without tendency to form a clot. Blood and fibrinogen were administered under pressure.

In the belief a large pelvic vessel had ruptured spontaneously, exploratory laparotomy was performed but no new clues were discovered. The patient's heart stopped; thoracotomy was performed immediately and the heart was massaged. Massage continued the beat of the heart for nearly two hours. During this critical period, generalized bleeding persisted and could not be controlled. Permission for autopsy was not obtained. Laboratory studies were not reported.

Cause of death: Missed abortion with afibrinogenemia.

COMMENT

The Committee studied the facts in this case with a great deal of interest; no one had ever encountered a case with such a bizarre progression of events. Members felt especially hampered by a lack of laboratory reports in the case. Again, it was believed that an early clue to the final diagnosis might have been obtained had laboratory studies been made at onset of vaginal bleeding after the dilatation and curettage. Had blood been obtained and started before the vaginal hysterectomy, the desperate situation might have been alleviated temporarily. The Committee voted this case a preventable death.

COMMENT OF CONSULTANT

The following comment of a consultant who is a specialist in Obstetrics and Gynecology, was given at the request of the Committee.

In recent years a great deal of attention has been focused upon the insidious and disastrous complication of pregnancy known as afibrinogenemia. Uncontrollable hemorrhage associated with pregnancy at any stage is alarming to the obstetrician and cannot help but leave him with a feeling of abject humility if his patient dies. In 1901 DeLee described the condition as temporary hemophilia. Murphy et al.[1] associates the condition with at least three or more situations in pregnancy, (1) severe abruptio placentae, (2) amniotic fluid embolism, (3) long retention of a dead fetus in utero, (4) postpartum hemorrhage and (5) surgical trauma, etc. The three cases selected by the Committee are excellent examples of *these* situations. Phillips, et al.[2] attribute the phenomenon to activation of the fibrinolytic enzyme system, declaring the intravenous administration of fibrinogen increased blood fibrinogen levels and resulted in a control of abnormal bleeding.

Case No. 42. In this case it would seem that the "Dead Fetus Syndrome" plus abruptio placentae applied to the situation causing afibrinogenemia. In support of the Committee's comment, early recognition of the cause of any hemorrhage provides a basis for prompt and specific therapy. It is easy and inexpensive to test venous blood (withdrawn from the arm) for clot formation and at the same time crossmatch for transfusion. Obviously the ruptured lower segment of the uterus contributed to the progress in the patient's "downhill course," yet it is reasonable to assume she was not even a *fair* operative candidate for hysterectomy.

Case No. 131. This case displays conservative, sound management, yet as the Committee points

out, an early discovery of the clotting defect in maternal blood is highly important.

Case No. 144. The retention of a dead fetus with (necrotic) placental tissue is exemplified in this case as a contributory factor in developing afibrinogenemia. However, in consideration of surgical trauma as a second factor, it would hardly seem feasible to impose it upon a patient who already is predisposed to a hemorrhagic phenomenon. Again prompt recognition of the defect in clotting of maternal blood might have provided grounds for earlier therapy.

Afibrinogenemia as we know it today, imposes a serious hazard upon certain obstetrical patients. Until a reliable prophylactic measure is developed for use in the patient routinely, propitious management of a case of afibrinogenemia must depend on (1) *early* detection by either simple or complex laboratory studies, and (2) *prompt* treatment (arrest hemorrhage, and administer fresh whole blood, and fibrinogen).

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1. Murphy, Christopher J., Jr., et al.: Afibrinogenemia. Am. J. Obst. & Gynec., 72:1197-1206, December, 1956.
2. Phillips, Louise Lang, et al.: The Role of Fibrinolytic Enzyme System in Obstetrical Afibrinogenemia. Am. J. Obst. & Gynec., 73:43-56, January, 1957.

Physical Exercise Essential for Maintenance of Healthy Body

Even though there is overwhelming evidence to indicate that graduated, physical exercise is essential for the maintenance of a healthy body, there are very few people who regularly follow this practice. We all recognize that some form of activity out of doors stimulates the appetite and promotes more restful sleep. It provides a sense of well-being unequaled by any other type of exercise.

When this type of activity is not possible, then some type of setting up exercise indoors helps increase total body metabolism as well as accelerate our general circulation, increase body temperature and prevent a great deal of mental sluggishness. Nerve tension is lessened, exercise serving as an outlet for pent-up pressure.

We are all aware of what happens to the arm or leg kept immobilized too long in a cast. Sitting or standing for long periods without some activity creates a stiffness and aching of joints when motion is attempted.

Early ambulation, postoperatively and following childbirth, decreases the period of convalescense, as well as lessening the likelihood of peripheral phlebothrombosis and pulmonary stasis. Less prolonged bedrest after cardiac infarction has likewise decreased the incidence of thromboembolic complications to say nothing of improving the patient's outlook psychologically.—A. Hazen Price, M. D., Panel Discussant, on "Preventive Geriatrics": *J. Michigan M. Soc.*, 56:589-610, May, 1957.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met at St. Ann's Hospital in Columbus on Thursday, May 16, 1957, and presented the following two cases before the general staff meeting of St. Ann's. Future meetings of the Franklin County Pelvic Cancer Delay Committee will be held alternately before the general staffs of the community hospitals and the Columbus Health Center.

Case No. 1: The patient, age 54, Gravida II, Para II, had uneventful menopause at age 47. Four years postmenopausal, patient began bleeding. She saw her physician who gave her "shots" to control the bleeding for three years. At times the response to the shots was good; other times, not. No pelvic examination was done during this time.

The patient then changed physicians. A pelvic examination and papanicolaou smear were done and she was referred to St. Ann's Clinic. Given four units of blood.

A dilatation and curettage and biopsy were done and the pathological report was adenocarcinoma, Grade III malignancy. She received intracavitary radium, 4320 mgm. hours, and 4200 mgm. hours.

The patient was re-admitted for a total hysterectomy, bilateral salpingo-oophorectomy. She had an uneventful recovery and no distant metastases were found. Last seen in March 1957, and was doing well.

COMMENTS

Physician delay of three years.

Again, no pelvic examination was done while patient was bleeding.

Postmenopausal bleeding is abnormal and an examination should definitely be done.

Proper Treating of Patient (Case 1): (1) History; (2) Pelvic examination regardless of bleeding; inspection and palpation; (3) Dilatation and curettage and cervical biopsy; (4) No medical treatment until after dilatation and curettage.

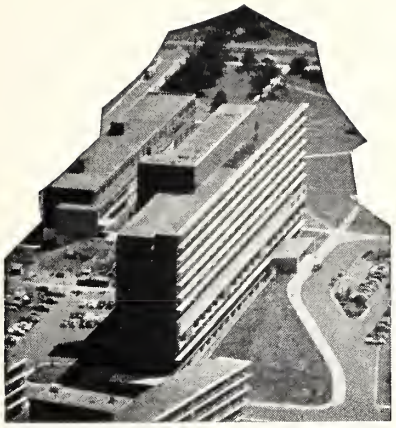
Case No. 2: The patient, age 33, Gravida II, Para I, Abortus I, had been treated for two years for chronic cervicitis, vaginal discharge, and vaginitis, without relief.

Patient changed physicians. She was followed for two months with no improvement. Admitted for dilatation and curettage and biopsy. This was done with a diagnosis of epithelioma of the cervix, Grade II malignancy, Stage I. She had intracavitary radium and Manchester colpostat. She received 4320 mgm. hours (4000 r.) to point A. She received 3600 mgm. hours (3500 r.) by intracavitary radium and Manchester colpostat. She was then referred for deep therapy.

COMMENTS

Physician delay two years.

Proper Treating of Patient (Case 2): (1) History; (2) Examination; (3) Papanicolaou smear; (4) Smear for vaginitis; (5) Treatment of cervicitis; (6) Biopsy or cone if no improvement or healing after 6 to 8 weeks.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Ralph J. Johansmann, M. D., President

Presented by T. S. Danowski, M. D., and Emmerich von Haam, M. D. Edited by Dr. von Haam

PRESENTATION OF CASE

A 44 YEAR OLD white female was admitted to the Urological Service of the Ohio State University Hospital complaining of low back pain of five months' duration and pain in the left flank, without radiation, of six weeks' duration. Concurrently she had developed chills and fever up to 104° F., persisting for approximately one week and associated with nocturia. No history could be obtained of hematuria, pyuria or dysuria. She was anorexic and had lost 13 pounds in approximately three months. For two weeks prior to the present admission she had been hospitalized elsewhere and had been told that she had pus on the outside of her kidney.

She had had an appendectomy approximately seven years previously. She also had suffered from diabetes mellitus for the past 20 years and had been recently treated with diet and a combination of 40 units of regular insulin and 10 units of protamine zinc insulin each morning.

PHYSICAL EXAMINATION

The patient was a malnourished white female who appeared chronically ill but in no acute distress. She was alert and cooperative. Her blood pressure was 126/80, her temperature 100.2°F., her pulse 86 and regular, her respirations 18. Complete physical examination revealed the following abnormalities: a Grade II diabetic retinopathy in both fundi; a red, smooth tongue with atrophic papillae; atrophic breasts; a mass palpable in the left mid-abdomen which was tender and was presumed to be left kidney. Pelvic examination performed by a gynecologist noted bilateral adnexal fullness and thickness but no definite mass was described.

LABORATORY DATA

Blood studies showed a red blood count of 3.73 million, a hemoglobin of 10.8 Gm., a white blood count of 10,050 with 74 per cent neutrophils, 26 per cent lymphocytes. The admission urinalysis showed a specific gravity of 1.025, a *p*H of 5.5, a protein content of 5 mg.; sugar was 3 plus, acetone was negative; the urinary sediment showed an occasional white blood cell, 12 red blood cells and rare epithelial cells per high power field. The blood urea nitrogen was 19 mg.; the fasting blood sugar 312 mg.; the CO_2 combining power 46.5 vol. Urine culture grew Aerobacter aerogenes. An electrocardiogram was essentially normal.

ROENTGENOGRAPHIC STUDIES

X-ray studies of the chest revealed scattered calcifications and increased bronchovascular markings in the lungs suggesting probable healed histoplasmosis. An excretory urogram showed no abnormality of the right kidney. No function was demonstrated in the left kidney and the left kidney shadow appeared enlarged. The x-ray diagnosis was "a non-functioning and enlarged left kidney." Left retrograde urogram showed a hydronephrosis with hydroureter and a chronic pyelonephritis. The possibility of a tuberculous process could not be excluded.

HOSPITAL COURSE

Initially the patient was maintained on a diabetic diet containing 1500 calories and regular

*This clinicopathological conference was presented before the Winter meeting of the American Diabetic Association in Columbus, February 1, 1957.

insulin four times daily averaging between 10 and 30 units daily. Her oral intake remained very poor. Eight days after her admission a left nephrectomy was performed. Following the operation the patient's oral intake remained poor and required supplementation with intravenous fluids. A persistent diarrhea developed which was thought due to tetracycline. Because of the presence of peripheral edema and an enlarged tender liver, the patient was digitalized. Two weeks postoperatively the patient refused to eat, became dyspneic and developed oliguria.

Laboratory studies on this date showed a blood sugar of 807 mg.; a CO_2 combining power of 23 vol.; a blood urea nitrogen of 58 mg.; the serum sodium was 112 mEq., the serum potassium 5.2 mEq., and the chlorides 85 mEq. Urine specimens were unobtainable. The serum acetone was strongly positive.

INSULIN INCREASED

Treatment with increased doses of regular insulin to a total amount of 100 U. in 12 hours was given, as well as 1,600 cc. of 5 per cent glucose in saline and 500 cc. of 1/6 molar sodium lactate intravenously. The urinary volume increased and although initially glycosuria was present, urinary sugar and acetone rapidly became negative. Although the acetone remained negative, acidosis persisted clinically. The CO_2 combining power at this time was 35 vol. Three hundred cc. of 5 per cent sodium chloride was administered intravenously. Following this the serum sodium rose to 130 mEq., the potassium dropped to 4.5 mEq., the CO_2 combining power rose to 44 vol. Blood sugars returned to approximately normal level. Despite the foregoing measures the patient became anuric.

Because of the anuria the patient was maintained on restricted fluid intake ranging between 900 and 1,200 cc. daily, all of which was given intravenously. Increasing edema of the legs, trunk and arms was noted and because of this, insulin was given intravenously. On this program the patient became intermittently mildly hypoglycemic, blood sugars being reported as low as 44 mg. There was a gradual increase in the blood urea nitrogen to a maximum of 140 mg.

Ten days later diuresis began and within two days time had reached a maximum of 3,200 cc. in 24 hours. The edema decreased markedly and the blood urea nitrogen gradually decreased to a low of 66.5 mg. She again began to take oral feedings. Three days later the serum sodium was 142 mEq., the potassium 3.2 mEq., and the chlorides 108 mEq. Co_2 combining power was 49 vol., the blood urea nitrogen was 67 mg., and the blood sugar was 33 mg. It was felt that the patient's general condition had improved considerably.

On the next morning the patient was alert and ate a liquid lunch fairly well. She was last observed at noon, at which time her condition was reported good. At 1:30 p.m. the patient was found to have expired. The mode of exitus was not observed. A blood sugar drawn postmortem was 66 mg.

CLINICAL DISCUSSION

Dr. T. S. Danowski, *Professor of Research Medicine, University of Pittsburgh:* This patient's main symptoms at her admission were pain in the lower back of five months' duration and pain in the left flank of some six weeks' duration. This second period of pain was accompanied by chills and fever. The symptoms of back pain would suggest the possibility that she has some renal disease, and the appearance of fever raises the possibility of pyelonephritis, which is strengthened by the symptom of nocturia, despite the fact that she denied gross hematuria and dysuria.

At first glance this looks like a diabetic with the increased tendency toward urinary tract infection that we find so frequently in diabetic women, although we must keep also in mind some of the rarer lesions, such as renal papillary necrosis. Another possibility is that she might have a perinephritic abscess, because simple pyelonephritis does not give you usually a temperature of such a high degree except when we are dealing with an acute exacerbation.

Now there is one fact in the history that troubles me a little bit and that is that she had lost 13 pounds in approximately three months, and even with a chronic urinary tract infection I would not expect this to happen. The assumption is that during this time her diabetes was fairly well controlled. So granting that she probably has a urinary tract infection of undetermined origin, one has to raise the question whether this patient has some other major illness which is responsible for her weight loss in the absence of any evidence that her diabetes was unregulated.

THE ABDOMINAL MASS

Her retinopathy is quite in keeping with diabetes of 20 years' duration, on a statistical basis at least. Her breasts were described as atrophic, and in a woman of 44 this might or might not be an acceptable finding. A very important point is the presence of a mass in the left mid-abdomen which was tender and was thought to be left kidney, but of course one would think of a left liver lobe or of an enlarged spleen, in addition to the possibility that she might have something in the bowel which presented itself as a mass.

The second finding which I consider significant was that of bilateral adnexal thickening and fullness in the pelvis, reported by the gynecologist, even though a definite mass was not described. So the physical examination adds two positive findings to the history: first, some type

of intra-abdominal pathology which could be kidney, spleen or liver, and evidence of some type of pelvic disease involving the tubes and ovaries.

Now let us consider the laboratory studies. Her blood count is normal and she does not appear to have leukemia. The urine analysis is largely of the type you would find in an old diabetic. The specific gravity has to be disregarded because she has sugar in the urine. She has a small amount of protein. Patients may have retinopathy without having nephropathy, and the sediment is abnormal only in that 12 red blood cells were present. I would assume that this was a consistent finding and that it was not related to catheterization, and that this microscopic hematuria was present on more than one examination.

One might be disturbed a little bit by the absence of white cells in the urine in pyelonephritis, but there is such an entity as "burned out" pyelonephritis and under those circumstances the absence of white cells would not be surprising. The blood urea nitrogen at the time of admission was 19 mg., which is not particularly remarkable. The blood sugar is in keeping with the fact that she has diabetes. The CO_2 combining power was somewhat reduced and we are faced here with an abnormal finding—a reduced CO_2 in a patient who has well-controlled diabetes. The urine culture does not mean anything, and the EKG was normal.

CHEST X-RAYS

The x-ray of the chest suggested probable healed histoplasmosis. It is not my impression that histoplasmosis is endemic in this area, assuming that this patient came from this area, and I do not know how to interpret this finding. I would consider too the alternative possibility of tuberculosis, which probably was excluded on the basis of the appearance of the lung or by suitable testing.

In the excretory urogram they found nothing wrong with the right kidney, but no function in the left kidney, which was described as enlarged. A retrograde pyelogram showed a hydronephrosis and hydroureter with thickening and tortuosity of the ureter suggesting some chronic process and possibly pyelonephritis. The possibility that some mass or stones might account for the incomplete filling of the lower calyces seems indeed a strong one, and the urologist said that he could not exclude a tuberculous process. On the other hand, there is no destruction of the kidney parenchyma described compatible with either renal papillary necrosis or tuberculosis.

It was decided to remove the left kidney and Dr. von Haam in time will show us what the surgical specimen showed. Following surgery the patient developed anorexia which lasted longer than the urologist would ordinarily expect, and then the patient developed diarrhea which was explained as due to tetracycline. She developed a peripheral edema and a large tender liver which were interpreted as congestive heart failure, although we do not have any other evidence for this specific point—no venous pressure, no circulation time, no statement whether she had rales. Maybe her diabetes got a little out of hand and she got a big liver on that basis.

Two weeks after the operation she stopped eating completely, became dyspneic and developed oliguria. Her CO_2 dropped to 23 vol., which suggests that this dyspnea was really Kussmaul breathing, since 10 mEq. per liter or 22 vol. CO_2 roughly marks the point at which overbreathing is about to set in. With this she had an elevated blood sugar and a positive serum acetone, suggesting that she was indeed in acidosis. The blood urea nitrogen was high, which would suggest that she had significant renal failure. The elevated potassium is in keeping with the fact that potassium is usually high in the presence of acidosis and coma. The patient was very properly treated with additional amounts of regular insulin and received 5 per cent glucose in saline and 1,600 cc. of 1/6 molar sodium lactate.

One fact, however, bothers me and that is the low chloride. Now the chloride can be low in patients with acidosis and coma if they lose it in vomitus; the sodium, however, is usually not this low. It suggests that this patient for some reason or other suffered from a low-salt syndrome, and there are several possibilities that could explain this. Certainly one of the important ones would be that this patient had become sodium-depleted, but how? The history does not tell that she had been vomiting, and even if she had I doubt that the sodium would get that low. She has acidosis coma and glycosuria and is losing sodium, but again I would not expect her to go down to 112. So I have to postulate that there is something wrong in addition with the regulation of her electrolyte metabolism beside ordinary acidosis or coma.

She received 20 grams of salt in water and with this her urine volume increased rapidly, which would support the notion that her oliguria was on the basis of sodium depletion. Her urine cleared rather quickly of sugar and acetone, suggesting that this patient had not been in acidosis and coma for long. This fact again makes us very suspicious of the very low sodium of 112 mEq. Then the other thing that is troublesome is the persistent acidosis, which I interpret as metabolic acidosis on the basis of her hyponatremia.

Then they gave her additional amounts of sodium chloride intravenously and succeeded in raising the serum sodium toward normal, but the CO_2 combining power remained low and the patient became anuric. This suggests that the patient actually had a sodium depletion. The patient must have also had some circulatory col-

lapse and she developed acute tubular damage—lower nephron nephrosis. They began treating her very properly with fluid restriction, but in spite of this the patient got more fluids than she really needed, because she developed edema. Because of this edema she got some insulin intravenously, which made her mildly hypoglycemic. Presumably she received the insulin intravenously and her hypoglycemia might have been due to inadvertent overinsulinization. But perhaps it was related to something else; the development of an insulin sensitivity.

Her blood urea nitrogen rose to 140 mg., while her anorexia and anuria persisted. Then finally after 10 days she began to urinate. This seems to me a very proper time for a patient to have a diuresis following lower nephron nephrosis. Of course this is always an exciting period in the life of a patient and of everybody who is taking care of the patient, and one of the gratifying things is the slow but steady decline of the blood urea nitrogen, which was noted in this patient. Such convalescent kidneys are incapable of making normal regulatory adjustments and you may find sodium depletion appearing in such patients. You might find potassium intoxication, and you might find tetany as a consequence of calcium losses.

In other words, the kidneys are apt to do pretty much anything, so you have to watch such patients carefully. This apparently was done and the patient began feeling well and started to take food by mouth. Her serum sodium became normal and so did the serum potassium and the chlorides. Everything seemed wonderful. The CO_2 combining power was still a little low and her blood urea nitrogen was still somewhat elevated. This may mean persistence of some degree of renal failure. Her blood sugars at that time showed that she had insulin shock and everything seemed going fine. She probably was asking when she could go home and the doctors were putting her off. One day after her lunch she expired. They got a blood sugar post mortem of 66 mg., which proved that she did not die of hypoglycemia.

DIFFERENTIATION

There are several diagnoses one can propose. First of all we can say that this patient had diabetes mellitus with retinopathy. It would seem to be a reasonable diagnosis that she had pyelonephritis with hydronephrosis and hydroureter, for which she had a nephrectomy. We can state that she had a resolving lower nephron nephrosis with tubular damage, and I would say that this was secondary not to diabetic acidosis and coma but to sodium depletion.

I think that the sodium depletion was probably on the basis of adrenocortical insufficiency since the patient was losing much more sodium than she should have. The alternative would be pyelonephritic or salt-wasting kidney, which resembles the kidney of adrenocortical insufficiency. You can differentiate these two by giving desoxycorticosterone or steroids and demonstrating a response in the Addisonian kidney while the chronic pyelonephritic does not. This was not done. I like the idea of adrenocortical insufficiency because this patient also developed insulin sensitivity. I think that they were aware of the fact that this patient probably did not need as much insulin when she was convalescing as she did previously and they were cutting it down; but in spite of this she fooled them and went into hypoglycemia. This would fit in with cortical insufficiency because under those circumstances we would expect a decreased gluconeogenesis.

The conversion of amino acids, glycerol and perhaps fatty acids to glucose is diminished at the same time the normal blockade exerted by the adrenal corticosteroids on the action of insulin on the tissues in the periphery is removed. For this reason a given amount of insulin does a better job. Then of course the livers of patients with Addison's disease, adrenocortical insufficiency, are low in glycogen, so that in between eating and infusions the patient would not have stores to draw on readily, and if she has adrenocortical insufficiency she probably also has an insufficient adrenal medulla. In the absence of an active adrenal medulla she would not have the epinephrine component of the hypoglycemic to release liver and muscle glycogen for conversion into glucose.

So from a physiological viewpoint I think that this patient had developed adrenocortical insufficiency on top of her chronic diabetes and her chronic pyelonephritis. She also has gone through an additional kidney complication, that of lower nephron nephrosis. Now to what etiology might we ascribe this syndrome? First of all, in the history we find that there was something wrong in the lungs which was called histoplasmosis but which could also have been tuberculosis. The urologist stated that they could not rule out tuberculosis in the kidney, and finally the pathologist has not yet reported what that kidney showed. We could try putting the whole symptom complex together and say that the patient had tuberculosis with Addison's disease. I have glossed over the diarrhea which was attributed to tetracycline. Maybe we could argue that it was tuberculosis also.

Now there is an alternative to tuberculosis, and perhaps we should take seriously the suggestion that this patient had histoplasmosis and try to interpret the patient's disease as histoplasmosis of Darling. There has not been much reported experience with this infectious disease but there is enough information to indicate that you can get adenocortical insufficiency, involvement of the gastrointestinal tract with intractable diarrhea,

and of course you get lesions of the lungs. I therefore would propose a pathologic anatomic diagnosis of either histoplasmosis or tuberculosis.

CLINICAL DIAGNOSIS

1. Infectious granuloma, probably histoplasmosis, involving lungs, kidneys, adrenals and pelvic organs.
2. Healing lower nephron nephrosis of right kidney.
3. Severe adrenal insufficiency (Addison's syndrome).
4. Diabetes mellitus.

PATHOLOGICAL DIAGNOSIS

1. Transitional-cell carcinoma of the left ureter with metastasis to lungs, ovaries and adrenals and extensive retroperitoneal involvement.
2. Necrotizing papillitis of right kidney.
3. Diabetes mellitus.
4. Status post left nephrectomy.

PATHOLOGICAL DISCUSSION

DR. EMMERICH VON HAAM: Gentlemen, the surgical specimen of kidney removed from this patient showed all gross markings of an acute pyelonephritis. Microscopic sections confirmed this gross impression, and the kidney parenchyma showed extensive patchy infiltration with leukocytes. The glomeruli showed changes compatible with diabetic glomerulosclerosis without any changes in the renal arterioles and arteries. Sections of the pelvis showed a markedly irregular proliferation of the transitional-cell epithelium which in some areas resembled the picture of carcinoma in situ seen in the cervix.

Sections through the portion of ureter removed with the kidney showed multicentric foci of transitional-cell carcinoma. The tumors seemed to arise from the Brunn's nests but had already invaded the muscle and produced obstructing tumor masses. This was then the diagnosis made on the surgical specimen.

At autopsy the body was emaciated; no edema was demonstrable. Both pleural cavities contained a considerable amount of serosanguineous fluid. The heart was small and showed severe brown atrophy. The lungs were studded with small yellow-white nodules measuring up to 1 cm. in diameter. The pancreas was surrounded by soft white tumor tissue encroaching from the retroperitoneal space. The left adrenal was nearly completely destroyed by whitish tumor tissue, while the right adrenal appeared grossly normal. The left kidney was absent. The right kidney showed necrosis of the papillae and a ureter which was imbedded in the retroperitoneal tumor mass.

The mass appeared to involve all retroperitoneal and periaortic lymph nodes, extending from the level of the renal hilus to the urinary bladder. The inferior vena cava appeared invaded by the tumor, which protruded into the lumen of the vessel. The remaining portion of the left ureter was imbedded in tumor tissue and showed a papillary tumor in the distended lumen approximately 5 cm. above the bladder opening.

MICROSCOPIC EXAMINATION

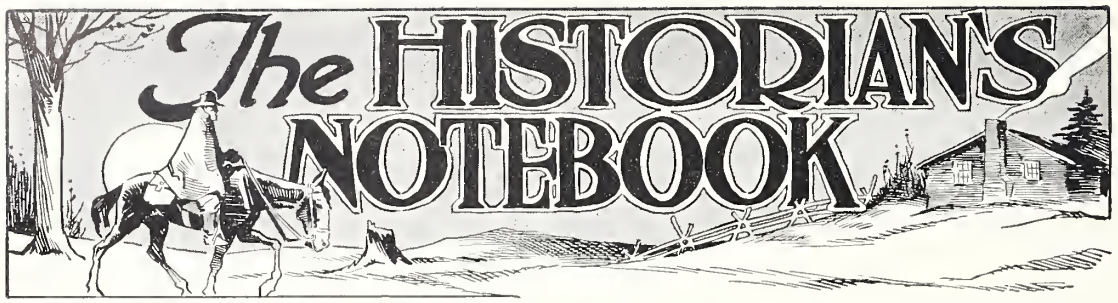
Microscopic sections showed myocardial fibrosis of not too severe degree. The lungs were studded with tumor metastases and showed hemorrhagic edema suggestive of shock. The liver was free of metastasis and showed the glycogen masses in the nuclei commonly found in diabetes. The pancreas appeared severely invaded by metastatic tumor growth. Pancreatic islands consisted of cells suggestive of alpha cells. Sections of the kidney showed changes in the parenchyma similar to those found in the surgical specimen. The absence of any vascular sclerosis in spite of a glomerular lesion suggestive of Kimmelstiel-Wilson disease rather agreed with the absence of clinical hypertension in this patient. There was an acute necrotizing papillitis present which may have been part of the lower nephron nephrosis.

Both adrenal glands showed microscopically severe destruction by invading and metastasizing tumor. Sections of the left ureter showed several additional foci of transitional-cell carcinoma similar to the one described in the surgical specimen. The tumor had also produced extensive metastasis to the ovary and had invaded the vena cava and the aorta.

SUMMARY

In conclusion, we have before us a case of carcinoma of the left ureter causing an acute left hydronephrosis with pyelonephritis and producing extensive metastases to the adrenal gland, ovaries, lungs and retroperitoneal lymph nodes. It is the tumor with ties all symptoms of the patient together into one picture, as Dr. Danowski tried so hard to do.

The important lesson of this case is that the patient did not act physiologically as a tumor patient. Her symptoms were dominated by evidence of severe metabolic disease with electrolyte and renal disturbances, and the metastases, although they proved very extensive at autopsy, never attracted clinical attention. I do believe that we can explain now the acute adrenal insufficiency which was so well deduced by Dr. Danowski as the direct result of the tumor metastases. We also can explain the x-ray picture in the lungs, the findings of the gynecologist, and the weight loss of the patient by the same disease. The death of the patient was caused by severe acute hemorrhagic edema, as we see in shock or severe electrolyte imbalance.



One Hundred Years of Progress of The Columbus State School

WENDELL A. BUTCHER, M. D., and MARY KNOCHE, B. A.

PART II

(Concluded from March Issue)

1907-1917

MAY 15, 1907, Dr. E. J. Emerick became superintendent of both the home and farm institutions. At this time, pupils began to spend a half-day in academic classes and the other half in industrial shops. More stress was placed on industrial training.

A Research Department, to give physical and mental tests, make family history and environmental studies and carry on observations of the patient's institutional life, was established in 1911. Also at this date the Board of Administration was created to supersede the Board of Trustees.

The State Bureau of Juvenile Research (under the jurisdiction of the Board of Administration) was established by an Act of the Legislature for the purpose of making mental, physical and other examinations. This Act became effective July 1, 1914.

In 1912, a request was made for a school building and $150,000 for improvements, for the next 10 years, at the home institution.

Special classes in the public schools came into being about this time.

1917-1927

The paramount concern, during the postwar period, was the expansion of institutions. Apple Creek was purchased to serve the northeastern part of the state and $300,000 was appropriated to purchase land for an institution in the southwestern part of the state.

Much building was done at Orient (over $2,000,000) and this period saw the completion of the fifth cottage at the home institution, to house mentally retarded delinquent girls. They were to be trained and placed in homes as domestics and nursemaids. It was estimated that two or three years' training would be sufficient. An Outpatient Department was created to place and supervise these girls. Dr. Emerick suggested colonies in various cities for this type of girl, but due to inadequate help this project did not materialize.

Another suggestion was that State Universities and Normal Schools train teachers, students, social workers and prospective physicians in preventive medicine, psychiatry, and mental hygiene in the methods of dealing with the mentally defective and subnormal. A training school, for special class teachers for the mentally retarded, was recommended to be set up at the Institution for Feeble-minded.

In April 1921, a reorganization code was enacted providing a Department of Public Welfare to take the place of the Ohio Board of Administration.

July 15, 1926, Orient was separated from its parent institution, with the latter remaining the Receiving Center.

This was a period of prosperity and expansion

The Author

Dr. Butcher, Columbus, is superintendent of The Columbus State School.

Miss Knoche, Columbus, is librarian at the school.

—the bakeshop, Tuberculosis Hospital, and Laundry at the home institution were opened.

Dr. Emerick resigned to go to the Bureau of Juvenile Research and Dr. F. L. Keiser became superintendent.

1927-1937

Although this was the period of the great depression some advances were made. A Clinic was organized and conducted for college students within a radius of 100 miles, and by 1930 eighty-two groups were participating in these clinics.

Recommendation was made to add a trained social worker to the staff, but this was not done until 10 years later.

A powerhouse and garages were erected at the home institution, and W. P. A. labor was used to remodel Cook Hall, raze Department 2 and an old smokestack, to repaint buildings, install water mains and hydrants, refinish furniture, repair and make clothing, et cetera.

The school had 739 enrolled in academic classes, with 23 teachers. The population had passed 2,000.

In 1928, a tract of land near Lebanon was purchased which was to be operated by the Longview State Hospital until it could be developed into an institution for the mentally retarded. This institution would serve the southwestern part of the state. Apple Creek was opened in 1931, but little building was accomplished.

1937-1947

This was the period of World War II, and our boys contributed to the war effort by weaving camouflage nets for which they received the Navy E.

The state was divided into two districts in 1937, and Orient began to receive patients directly from the counties.

In 1939, the Division of Mental Hygiene was created within the Department of Public Welfare.

Sunnyside was rehabilitated for the cripples, but due to the scarcity of help they were unable to staff it.

1945 marks the change of the names of the institutions for the feeble-minded to "State Schools."

$50,000 was appropriated for residences for two physicians which were constructed on the south side of the campus.

The staff was enlarged by one physician (making a total of three), one x-ray technician, one laboratory technician and one social worker.

A family care program for the mentally retarded was instigated in Ohio to operate from Apple Creek and Orient State Schools and by September of the following year 50 patients had been placed from Orient alone.

In 1945, research—seeking reasons for mental deficiency resulting from the presence in their blood of both Rh factors and Rh antibodies—was a cooperative project of the Division of Mental Hygiene of the Ohio Department of Public Welfare, Children's Hospital, Ohio State University Departments of Pediatrics and Zoology, carried on at the school, with Dr. Edith Offerman of the staff assisting.

Cambridge State Hospital was secured in 1946 and some of our non-ambulatory patients, along with working patients to care for them, were transferred there.

At the end of this period a 48-hour work week went into effect.

1947-1957

November 1949, fire again struck the school when the south wing of the central building was burned causing an estimated $300,000 damage.

By Executive Order No. 13 of May 15, 1950, the Columbus State School became a classification and reception center for the mentally handicapped, and received the services of the Medical School and the Bureau of Adult and Special Education of Ohio State University and other educational institutions. The Reception Center diagnoses and transfers to one of the following institutions: Orient State Institute, Gallipolis State Institute, Columbus State School and Apple Creek Hospital. Cambridge State Hospital cares for approximately 400 mentally retarded patients who had been transferred there during its first year of operation.

Dr. Keiser retired July 1, 1950, and was succeeded by Dr. Roger M. Gove. Many innovations followed. New departments were added and others enlarged.

A Psychology Department was created to help understand the needs of the individual and help plan a program to meet the needs, difficulties and special abilities of those committed to the school. This is accomplished through examinations, interviews and conferences.

The Social Service Department was expanded and a concentrated effort was made toward community placement. This was achieved through family care, colonies and work placement.

A Guidance Department was established. Its function is to follow the individual patient's progress and co-ordinate his training program.

Occupational Therapy is provided for many physically handicapped and emotionally disturbed patients who are unable to participate in the more formal training program.

The function of the Recreation Department is to provide opportunities for personal and social growth and to maintain a high level of morale through large and small group activities.

The Department of Education and Training was enlarged and includes academic school, occupational training, religious education and research. The broad aim of the training program

is to develop each individual to his fullest capacity. Under its guidance, academic and remedial classes, beginning with kindergarten groups and continuing as high in studies as individual children and adults are able to progress and benefit, have been established. The curriculum is a simplified one, with the practical aspects of training stressed. Special classes for those who have multiple handicaps are offered. Religious services are held regularly under the auspices of chaplains for the Catholic, Jewish and Protestant faiths.

In February of 1952, the Volunteer Service Committee (the first of its kind in any institution for the mentally retarded) was formed to coordinate the offers of assistance from the community into the program of the School. Through the efforts of this department (now known as the Special Services Department) a Parents' Volunteer Association, comparable to the P. T. A., was organized. This group is composed of parents of retarded children and interested individuals who work closely with the school.

Personnel Training Department provides an in-service training for all new employees and courses in nursing arts and child development for all patient-caring personnel. Other courses are given in ward supervision and administration.

The Clinic for the Mentally Retarded provides diagnostic services to the communities of Ohio regarding problems of retardation. It is concerned only with individuals not committed to the institution.

COUNCIL CLASSES

The first group effort by parents to meet the problem of the mentally retarded child excluded from the public school, dates back to 1931, and took place in Cleveland. 1933 marks the organization of the first Parents' Council for Retarded Children and was known as the "Cuyahoga County Council for Retarded Children."

November 1950, a committee was formed known as the State of Ohio Committee of Councils for Retarded Children and its duties were to introduce legislature to secure state assistance for community classes.

June 13, 1951, Senate Bill 157 was signed by the governor. The first class in Franklin County was held at the Columbus State School in 1951 as was the first Workshop for teachers of the Council classes.

The State Association of Parents of Retarded Children was chartered May 1952.

BOND ISSUE

In November 1955, a $150,000,000 building bond issue was voted upon and passed by the electorate of Ohio. It is hoped that this bond issue will achieve the aims of (1) balancing the rated capacity and actual population; and (2) balance admissions and discharges through the provision of (1) additional treatment facilities, (2) additional patient housing, (3) improved central facilities such as food service, and (4) rehabilitation of present facilities.

RESEARCH PROJECT NO. 50

Diagnosis and Educational Therapy With Brain-Injured Children

Planning for a research class began in the spring of 1951. The general objective is to develop psycho-educational methods, based on differential diagnosis of children with brain pathology, which will help to rehabilitate such children. This project is under the direction of a psychologist.

July 1, 1954, the Department of Mental Hygiene and Correction was formed, its powers separated from the Department of Public Welfare. An executive order established the Bureau of Mental Deficiency within this new department.

August 1954, Dr. Roger M. Gove resigned and Dr. Wendell A. Butcher became superintendent.

In the year 1956, a three-year project was undertaken at the Columbus State School. It is being sponsored by the American Association of Mental Deficiency with a grant from the National Institute of Mental Health. The project will explore the most significant problems in mental retardation and suggest methods for their study and solution. It also will look for areas for research and pilot studies, and encourage individuals and institutions to pursue work in these areas; encouragement of expansion of facilities for training professional personnel and promotion of in-service training for workers.

Physical expansion during this last decade has been the completion and occupancy of Emerick Hospital, Carlson Hospital, Roger M. Gove Hall (school building) and Doren Hall. Pineridge remodeling is near completion. Appropriations have been made for a 150-bed Reception and Diagnostic Center and a $1,400,000 Food Service building, which will also house the Food Service Training Center and Laboratory of the Department of Mental Hygiene and Correction, which was formally opened at the Columbus State School in June 1956.

Cat Scratch Disease

The earliest recognition of Non-Bacterial Regional Lymphadenitis as a definite disease entity is credited to Dr. Lee Foshay of Cincinnati, who, during his classical study of tularemia, noted certain patients who presented a clinical picture similar to the ulceroglandular form of tularemia, but with diagnostic findings incompatible with this disease. A common history of being scratched by a cat prompted Foshay to give this entity its colloquial title—Cat Scratch Disease.—David F. Merten, M. D., Richmond, Va.: *Virginia M. Monthly*, 84:304-308, June, 1957.

Ohio's Medical Heritage . . .

The President's Address Delivered Before the House of Delegates Of the Ohio State Medical Association, May 13, 1957, in Columbus

By RICHARD L. MEILING, M. D., Columbus

WE, of the medical profession, are humbly aware of frequent divine intercession in our care of the sick, injured and suffering and it is only fitting that we at this time pause for a word of silent prayer, asking, "that we physicians, assembled as Delegates to this House, may be blessed with the strength and understanding to meet the complexity of problems confronting our colleagues, our patients and our fellow citizens to the end that we may serve humanity in a manner befitting our dedicated medical profession."

During the past twelve months I have had an opportunity to query myself concerning the genealogy, organization and accomplishments of our association. I felt that you, too, might desire a review of our historical past and to that end I referred to the files of "The Historian's Notebook" as prepared by such authorities as Jonathan Forman, Robert G. Patterson, Linden F. Edwards and Howard Dittrick to mention only a few of the large number of interested and contributing authors. There are also many scattered references in the several libraries and private collections of material on this subject.

FIRST AMERICAN PHYSICIAN

Our entire nation this year is celebrating the 350th anniversary of the arrival, on May 13, 1607, (rather significant that today is the actual anniversary) of that hardy group of adventurers of the London Company who founded at Jamestown, Virginia, the first permanent English settlement in North America. One of the group was Dr. Thomas Wotton, the first physician to practice in this colony.

Included in the Mayflower group of Pilgrim Fathers who landed on the shores of Massachusetts on December 21, 1620, was Dr. Samuel Fuller, physician to this colony.

The medical attention of these two devoted English physicians, Dr. Wotton and Dr. Fuller, to their fellow colonists established a firm tradition upon which medicine has grown and flourished throughout our land, and spread in concept across the oceans.

MEDICINE IN COLONIAL DAYS

The beginning of the seventeenth century, however, was a period in world affairs marked by the gradual lifting of the medieval darkness through the illumination caused by the development of experimental physical science, and its divorce from the metaphysical pseudoscience so prevalent at that time.

Physicians in the early colonial days when remunerated at all, received their salaries as ministers, government officials, or teachers or earned their livelihood as farmers or retailers. As time progressed, particularly in the urban areas, the physician was given an opportunity to earn a living from the private practice of medicine. The doctors who braved the hazardous round-trip ocean crossing to complete their studies and improve their education in Europe and then return to North America were the ones who for the most part then entered into the private practice of medicine. This was not, however, always to the apparent liking of the colonial planners of socialist ideology. The "socialist" of those days even as of today was primarily interested in "something for nothing" at governmental expense.

REGULATIONS AND FEES

By 1639, a colonial law-making body, the General Assembly of the Colony of Virginia, was, by legislative act, attempting to regulate not only the practice of medicine, but also to establish "fee" schedules for "practitioners in physick and chyrygery." In 1736 the Virginia Assembly established fixed fees in the private practice of medicine based upon the University studies and degrees of the physician concerned. If I might be permitted a passing comment—how similar this attitude of 1736 to that of 1947 when Congress by legislative act directed that the salaries of the Veterans Administration physicians be established upon the basis of medical specialty board certification or lack thereof rather than upon proven professional excellency and capability of the physician. In several other colonies legislation was enacted regulating the practice of medicine and establishing fee schedules as well as, in some instances, "mileage allowances" for country visits to patients.

SIGNERS OF DECLARATION

It was, therefore, in this legislative environment and regulatory society that we find our physician ancestors at the time of the American Revolution. Leadership in the colonial government at all levels may well have been forced upon these physicians by economic and legislative necessity, but they responded with not mere political attainments but with statesmanship of the

highest order. Five such physician statesmen were among the original signers of the Declaration of Independence in 1776. (Oliver Wolcott of Connecticut, Josiah Bartlett and Mathew Thornton of New Hampshire, Benjamin Rush of Pennsylvania and Lyman Hall of Georgia.)

OHIO IN EARLY DAYS

Now let us turn to our own fair State of Ohio. Dr. Manasseh Cutler, physician, lawyer, Congressman and minister of Ipswich, Massachusetts, is credited with being the principal force which influenced Congress meeting in New York to enact "The Ordinance of 1787" creating the first government for the Northwest Territory, thus enabling the Ohio Company (and others) to purchase land for settlement along the Ohio River.

The pioneering Massachusetts and Connecticut parties of the "Ohio Company" joined forces under Rufus Putnam during the Winter of 1787-88 at Sumrill's Ferry, Pennsylvania. Here they built boats which were then to carry them to Fort Harmar, at the mouth of the Muskingum. On April 7, 1788, at the confluence of the Muskingum and Ohio, the first authorized settlement of Ohio called "Adelphia" was established. The name "Adelphia" was soon changed to "Marietta," we are told, in honor of Queen Marie Antoinette of France.

SETTLEMENT AT MARIETTA

In this day of rapid travel, be it by jet propelled supersonic aircraft or even with a mere 120 horsepower under the hood of the family car as it purrs along on our modern highways, it is perhaps difficult to understand that from the arrival of the London Company and Dr. Wotton in Jamestown, Virginia, until the arrival of the Ohio Company settlers at Marietta, 181 years had elapsed. The overland distance between Jamestown and Marietta is a little more than 400 miles.

This Marietta settlement was known for its academic, educational and cultural characteristics. One of the leaders of this community was Dr. Jabez True of Gilmantown, New Hampshire, who came to Marietta in 1788 and there established his private practice which he continued until the time of his death in 1823. Dr. True often traveled the waterways by canoe to visit his patients, and when so traveling was accompanied by two riflemen to protect him from hostile Indians. History records this first practicing physician of Ohio as "a gentleman of charity, simplicity of manners and sincere piety."

THREE POLITICAL COMMUNITIES

There were apparently three dominant political communities in this new "Ohio Country," Marietta, Cincinnati and Chillicothe. It is to Chillicothe that we next turn our attention and to a physician, statesman and public servant, Dr. Edward Tiffin. Dr. Tiffin was born (1766) and educated in Carlisle, England, then migrated with his family to Charles Town, Virginia (now West Virginia) in 1783 when he was 17 years old, and completed his medical education at the University of Pennsylvania. He established a medical practice in 1786 in Charles Town.

In 1793 he moved to Chillicothe and it was here that he rose to great eminence as a physician, surgeon and statesman. Dr. Tiffin holds the unique position of being elected unanimously and without opposition to the position of Speaker of the Ohio Territorial House of Legislation (1799), President of the Ohio Constitutional Convention (1802) and first Governor of the State of Ohio (1803). Still later he was elected United States Senator from Ohio, but apparently not being imbued with "Potomac Fever," he resigned this high office in 1809. He returned to Chillicothe and was elected to the Ohio House of Representatives where he served as Speaker of the House during the Eighth and Ninth General Assemblies. This urbane, cultured physician, surgeon, statesman and public official died August 9, 1829, in Chillicothe.

DR. DANIEL DRAKE

In the early Cincinnati community Dr. Daniel Drake, a stormy character, native of New Jersey, was perhaps the best known in the field of medical education, science and community life. It was he who helped found the Medical College of Ohio, the forerunner of the Cincinnati College of Medicine. He also played an important role in state medical affairs being most active in all organizational activities. Several contemporary authors have called him "the medical colossus of the West."

Let us now shift back to Marietta and pause in this rapid historical review to consider the influence of Dr. Samuel Hildreth upon medicine in Ohio.

HILDRETH'S INFLUENCE

Dr. Samuel Prescott Hildreth was a friend of Dr. Jabez True's brother who lived in New Hampshire and, we may assume, heard of the golden opportunities of the "Ohio Country" through correspondence between the True family. At the age of 23, Dr. Hildreth left New England and came to Marietta in 1806 to establish his practice of medicine.

Four years later he was elected to the Ohio House of Representatives, the youngest member at that time. The Ninth General Assembly, meeting in Zanesville in 1811, passed the first act to regulate the practice of medicine in Ohio. Dr. Hildreth was the author of this act known as Ohio Laws No. 9.

MEDICAL DISTRICTS

This act, reflecting the basic concepts of the New Hampshire Medical Society Laws and Regulations (1792), divided Ohio into five medical districts, and each district was to have three medical censors, (or examiners of physician candidates), appointed by the General Assembly.

Here for the first time in Ohio we find "medical districts" which were the very early forerunner of our medical counselor districts of today. This also was the first effort at medical licensure in our state.

The following year (1812) the General Assembly enacted legislation creating "The President and Fellows of the Medical Society of the State of Ohio," and further designated that a "medical convention" was to be held "on the first Monday of November" in Chillicothe. This law provided that a quorum of ten members (delegates or censors from the medical districts now numbering seven) was necessary to transact business. Fortunately or unfortunately, due, I am certain, to the lack of roads, bridges and to the impassable trails at this time of year, only five qualified members (Joseph Canly of Lebanon, Samuel Parsons of Columbus, Daniel Drake of Cincinnati, Joseph Scott and John Edmiston of Chillicothe) arrived in Chillicothe on the appointed day. Lacking a quorum, no meeting could be held. What an inauspicious beginning for the predecessor of the annual State Association meeting and Scientific Assembly which we now recognize as the highlight of the organized medical activities each year.

"MEDICAL CONVENTION"

In June 1821, in Columbus, Ohio, in compliance with the law of 1821, "The Medical Convention of Ohio" was duly held. We believe this to have been the first state medical meeting. An Act of 1824 conferred various powers over local medical societies upon "the general Medical Society of the State of Ohio." Here then is the precedence for the provisions today whereby county medical societies secure their charters from the Ohio State Medical Association.

I am certain by this time you, like your speaker, are convinced that, both in the colonies and in the early legislative sessions of the Ohio General Assembly, too much "law" was without a doubt retarding medical progress. Yet it must be noted that, in the early years of the nineteenth century the Ohio physicians were confronted with yellow fever, malaria, cholera, smallpox and typhoid and typhus epidemics. Diseases which few of us have treated in Ohio. They introduced vaccination procedures, and to one Ohio physician, Dr. John Richmond of Newton, Ohio, 1827, goes the credit for performing the first Cesarean Section to be reported in the United States. (Even as your President, I cannot forget my first love, namely, to the practice of obstetrics and gynecology; hence, point with pride to this event.)

VOLUNTARY REGULATION

The General Assembly finally realized the failure of legislative attempts to control medical professional practice, hence, in 1833 it repealed all previously enacted laws regulating the practice of medicine in the State of Ohio. Education, rather than legislation, was eventually to succeed in aiding the physicians to improve Ohio's health and to combat the widespread quackery so prevalent at that time.

The physicians, however, mindful of the needs of their fellow citizens, and, realizing that only by organized effort could such be met, created a "voluntary" state medical organization known as the "Ohio Medical Convention" in 1835 which continued to exist until 1851. Membership was open to all "regular physicians" throughout the state on an individual basis. The objectives of this "Ohio Medical Convention," as set forth in the "call-letter" issued by Dr. William Awl of Columbus, Ohio, included among other items a petition to the Ohio General Assembly to establish: (a) a Hospital for the Insane; (b) a School for the Blind; (c) Procedures for the Regulation of Smallpox Vaccination; and a petition to the United States Congress for marine hospitals to be established on the shores of Lake Erie for the seamen plying the Lakes.

Perhaps in all honesty I should mention that Dr. Awl raised the question of "prohibition" at this meeting—puritanic influence, I am certain!

WELFARE PROGRAM

Thus, the foundation for Ohio's welfare institutions was laid by Ohio's medical profession, and in 1838 the first institution for insane was opened in Columbus, Ohio, having been authorized by the General Assembly in 1835.

In 1839, at the Ohio Medical Convention held in Cleveland, we find that Dr. Peter Allen of Kinsman, Ohio, the first President of the Ohio Medical Convention, sponsored a resolution as follows:

"Resolved that a medical society be formed in each county of the State; that the first meeting be held on the last Tuesday of October next, and then semiannually, and that the subject of a State Society be referred to their consideration."

This was somewhat original for up to this time district medical societies had been the basic organization so that this resolution was perhaps the spark that was to eventually lead to the founding of our present Ohio State Medical Association with its chartered county societies. At this same time efforts were being made for the organization of a National Medical Association with constituent state societies. This was accomplished with the founding of the American Medical Association in Philadelphia, Pennsylvania, on May 5, 1847, when almost 250 delegates representing 40 medical societies and 28 medical colleges met in the hall of the Academy of Natural Sciences. Its founder was 30-year-old Dr. Nathan Smith Davis, New York, who later became president of the organization. Its first president was Dr. Nathaniel Chapman of Pennsylvania.

FOUNDING OF STATE SOCIETY

Rather significantly it was on the evening of May 14, 1846, in the Neil House in Columbus, Ohio—not, however, the same room or building

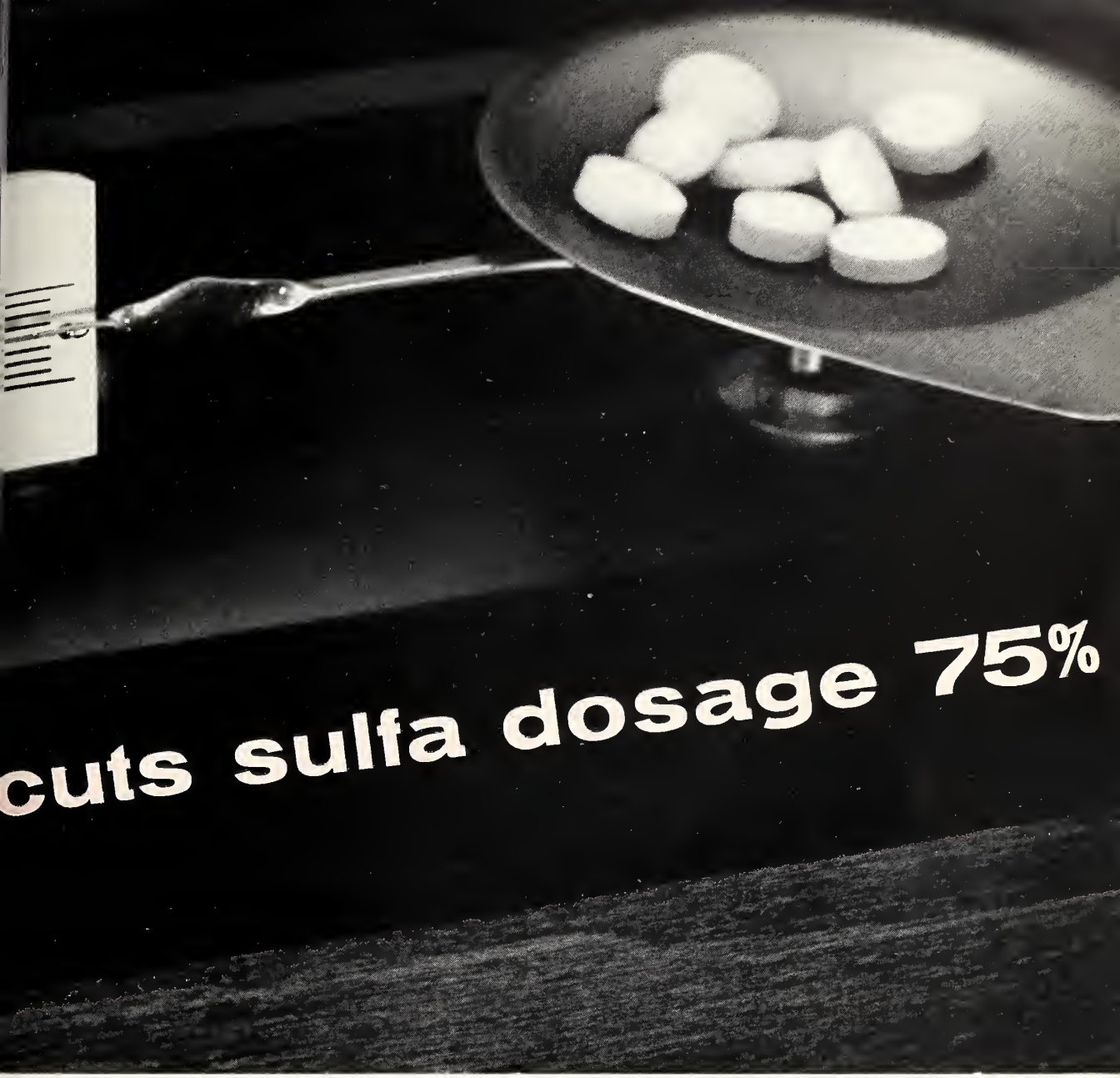
(Continued on Page 804)



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1. Boger, W. P.; Strickland, C. S. and Gylfe, J. M.: Antibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

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where we find ourselves on this evening of May 13, 1957—that a group of 25 medical gentlemen assembled to form the Ohio State Medical Society. Dr. G. H. Boerstler of Lancaster and Findlay, was elected the first President. Tomorrow is really our "Founders Day."

On February 22, 1848, the General Assembly of Ohio granted a charter in which our organization was, "made a body corporate and politic by the name of The Ohio State Medical Society."

Organizational problems involving district, county and state society responsibilities were difficult to resolve. Time, however, often is the best solvent to jurisdictional differences of opinion and so it was with our organization.

PRESENT ORGANIZATION SET UP

On May 28, 1902, a new Constitution and By-Laws was adopted which changed the name from "The Ohio State Medical Society" to "The Ohio State Medical Association." The House of Delegates was created with representatives from each county medical society. The component counties were then divided into the districts, and one representative, (counselor), was elected by the House of Delegates from each district to serve on the governing body, "The Council," of the State Association.

Through the years Ohio has proudly presented her physician sons as national medical leaders. Six of our colleagues have served as President of the American Medical Association: Reuben D. Mussey (1850), who was President of OSMA in 1849 and also a charter member of the Academy of Medicine of Cincinnati; George Mendenhall (1870) of Cincinnati; W. W. Dawson (1889), President of OSMA in 1871 and also Professor of Surgery at Cincinnati; C. A. L. Reed (1901), also one of the founders of the American Association of Obstetricians and Gynecologists and originator of the Pan-American Medical Congress; J. H. J. Upham (1937), former Dean of the College of Medicine of Ohio State University, and President of OSMA in 1914; Edward J. McCormick (1951), also President of OSMA in 1942.

This review of some of the high points of colonial and Ohio medical history may, I trust, better orient the new members of this House of Delegates to the organization and to the heritage of Ohio medicine. The record of our medical profession in support of the health needs of all the citizens of Ohio stands proudly upon its own record. The tradition and need for physicians to be alert to all aspects of legislative programs (local, state or national) is as great today as it was in the days of Dr. Tiffin and Dr. Hildreth, or the time of the five physician signers of the Declaration of Independence, or to our colonial forebears of the early seventeenth century.

TWENTY-FIVE POINT PROGRAM

In 1946 this House of Delegates indorsed a "25 Point Health Program for Ohio." The adoption of the various aspects of that program has benefited all of Ohio citizens during the past 10 years. The medical profession has demonstrated it is best qualified to guide developments affecting health be it by governmental directives, legislative acts or voluntary organizations.

PRESENT BASIC PHILOSOPHY

This past year your Council reiterated the concept that "the Association has neither the legal or moral right to contract the professional services of the individual members, nor to fix professional fees." Historically this was first publicly acknowledged in the legislative act of 1812 which established "the strict prohibition of 'fee' fixing by the (medical) society." I firmly believe it is not in the best interest of patient care for government, labor, management or insurance interests, by whatever the pretext or emotional appeal, to attempt to contract with medical societies or groups for the professional care of patients under programs with a "third party" fixing the fees, thus destroying an important aspect of patient-physician relationship.

INDEMNITY TYPE PLAN ENDORSED

Our Association has developed and sponsored the "indemnity type" medical care program which we believe serves the patient as well as the physician in the most equitable manner. Ohio Medical Indemnity organization with its 2,250,000 subscribers today amply demonstrates this fact.

FUTURE PLANNING

Projecting into the future, may I express my satisfaction in the preliminary development of "the Future Planning Committee" for our association. The rapid growth of the population of Ohio, the expansion of industry along our waterways, and the opening of the ocean trade routes, through the St. Lawrence waterway, to the shores of Lake Erie, will be dominant factors in the continued growth of the membership roles of our Association as well as in the social, economic and ideologic problems which our state and our Association must face. It is not too early to engage in anticipatory planning which will procure for us a permanent home for our executive staff, editorial and library facilities, Council and committee activities. This might well be accomplished in the form of a non-profit "foundation" responsible for all our scientific, educational and health programs.

MEDICO-LEGAL MATTERS

The recently adopted model "declaration of principles" between the Ohio State Bar Association and the Ohio State Medical Association for use by county bar and medical societies establishes for our respective professions mutual understanding and a basis for cooperation. It is with special pleasure that I commend the work of our

legal counsel, Wayne Stichter, and my friend of school days, Earl Morris, President of the Ohio State Bar Association for their sincere efforts in this undertaking. We of the medical profession have been neglecting the forensic medical armamentarium which is as necessary today in the practice of medicine in our complex society as is the knowledge of nuclear-biophysics (atomic-medicine) in the therapy and treatment of our patients. The scientific program chairman and his committee are to be commended for incorporating this timely subject in our Wednesday program. I trust proper steps may be taken by the Committee on Education to develop a program of education, seminars, etc., in all aspects of medical jurisprudence, for all members of our association as well as for our medical students who soon will be fellow colleagues.

Likewise it seems worthy of direct action on the part of our Committee on Chronic Illness, that they take positive steps to foster state-wide programs in the broad aspects of rehabilitation. Such a program should be coordinated with the several Rehabilitation Centers in Ohio, the Mental Hygiene and Handicapped Persons programs —now established by both voluntary and government agencies.

HISTORY OF OHIO MEDICINE PROPOSED

If memory serves me right, a President may exercise a "privileged" prerogative to make a request. My request would be that the House of Delegates ask The Council to give serious consideration to the preparation of an official volume (or volumes) of the "History and Development of Medicine and its Organization in the State of Ohio." I full well realize this is a considerable undertaking and will require time but I know no better time to begin than now. Hence, I submit it to you for your consideration.

Allow me to thank the members of Council, and the members of the hard-working committees, each of whom has sacrificed time and effort for you. Would that I might thank their wives, families and patients for sharing them with our organization this past year.

My deep appreciation for many kindnesses, logical advice and timely aid in the administrative work of the past twelve months goes to our loyal and sincere Executive Secretary, Mr. Charles Nelson, the Director of Public Relations, Mr. George Saville, and their assistants, Mr. Hart Page, Mr. Charles Edgar and Mr. Gordon Moore. To each member of the office and editorial staff I extend my personal thanks and that of the membership for work "well done."

This "team" of association officers, committees and administrative staff has made possible an administration dedicated to the health needs of our fellow citizens and to the maintenance of the highest professional medical standards by our colleagues. If it shall be said of this administration that it had some measure of success, the credit belongs to those whom I have mentioned; if any blame attaches to it, *mea culpa.*

QUALITY OF LEADERSHIP

I would like to suggest that in an organization with more than 8500 members, such as ours today, each delegate give serious consideration to the selection of officers, councilors and national delegates who by their interest in our medical organization have demonstrated a capability to best share the responsibility and to guide the destinies of our Association. We believe in democratic election processes and we must remember that to be nominated for office is in itself recognition and honor by associates and colleagues. There should be no embarrassment in not being elected to an office, only satisfaction in having been nominated. The criteria of selecting our elected representatives should be not the candidate's place of residence, membership in special organization or area of professional practice, but rather his capabilities in leadership and his experience in the broad aspects of medical organization, plus the belief in the future of free enterprise and the democratic principles of government. I trust due consideration will be given, where possible, to young men that they may have an opportunity to serve their Association.

May I thank you for the honor you conferred upon me, your President this past year. I shall cherish the memory of my participation in the many activities of the Association. I have the greatest confidence and admiration for our President-elect, Dr. Robert Martin and I look forward with pleasure to the privilege of serving as Past-President under him this coming year on The Council. May the deliberations and actions of this House of Delegates be motivated by the best interests of all our members and for the health of all our fellow citizens, and may each of us cherish the memory of that first Ohio practicing physician, Dr. Jabez True, known for his charity and simplicity of manner, who 169 years ago came to Marietta to care for the first Ohio settlers.

Cincinnati Academy Recounts 100 Years Of Progress in Published Volume

An outstanding contribution to the history of medicine in Ohio is a volume recently published by the Academy of Medicine of Cincinnati, entitled *The Cincinnati Doctors' Forum.*

This volume represents a documented account of the founding and progress of the Academy of Medicine of Cincinnati—a history of its first 100 years—and was published in connection with the Academy's centennial celebration in 1957. The book was compiled over a period of several years by a special Committee on History under direction of Dr. Reginald C. McCrane, professor of history in the University of Cincinnati.

The cloth-bound book is available at $5.00 from the Academy of Medicine of Cincinnati, 152 East Fourth Street, Cincinnati 2, Ohio.

Presenting . . .

The New President-Elect and One New Councilor Named at the Annual Meeting with Biographical Data on These and Other Council Members

THE House of Delegates of the Ohio State Medical Association named a new President-Elect and one new Councilor at the 1957 Annual Meeting in Columbus. Following are biographical sketches of these two officers as well as information about other members of The Council.

Dr. George A. Woodhouse, Pleasant Hill, was chosen by the House of Delegates as the President-Elect. He will succeed Dr. Robert S. Martin as President at the 1958 Annual Meeting in Cincinnati.

Dr. Woodhouse has devoted his entire professional career of 33 years to rural practice, most of it in Miami County. Paralleling his practice has been a devotion to medical organization work that has gained him recognition from the local to the national level. Four years ago his colleagues of the Miami County Medical Society honored him at a testimonial dinner upon completion of 25 years as secretary-treasurer of the local organization. He had served as Councilor for the Second District since 1953 and has contributed in numerous other ways to the work of the State Association. On the national level he has continuously served as Delegate to the American Medical Association since 1942 and for four years has been a member of the Judicial Council of the AMA. The Judicial Council has been called medicine's supreme court. Its function is to interpret the AMA Principles of Ethics.



GEORGE A. WOODHOUSE, M.D.

As early as 1936 Dr. Woodhouse was elected president of the Second Councilor District Medical Society and later served several terms as its secretary. He was first elected a delegate of the Miami County Medical Society to the OSMA in 1936 and served in that capacity until 1953. He has served the State Association in many capacities—as a member of the first Judicial and Professional Relations Committee; a member of the committee to study plans for pre-payment insurance, a program which resulted in establishment of Ohio Medical Indemnity; member of the Committee on Public Relations and Economics; member of the Subcommittee on Legislation and its chairman from 1949 to 1953; member of the House of Delegates Reference Committee on Resolutions on many occasions; chairman of the Committee on Hospital Relations for one year; and a member of the Auditing and Appropriations Committee.

Dr. Woodhouse is a graduate of the University of Cincinnati College of Medicine, Class of 1924. He is a member of the active staff of Piqua Memorial and Dettmer Hospitals and on the courtesy staff of Stouder Memorial Hospital, all in Miami County. He is married and the father of four children, all adults. One son, Dr. George A.

Woodhouse, Jr., is a practicing physician in Cincinnati.

Dr. Woodhouse is a member of the Hospital Advisory Council of the Ohio Department of Health. Community activities include membership on the local Board of Education and the Pleasant Hill Board of Public Affairs of which he has been president for eight years. He is a member of the Congregational Christian Church, the American Legion (as a veteran of World War I) and several Masonic bodies including the Shrine.

INCOMING PRESIDENT

Dr. Robert S. Martin, Zanesville, assumed the office of President at the conclusion of the last meeting of the House of Delegates.

Dr. Martin's elevation to the high honor and position of responsibility among his Ohio colleagues, comes as a peak in career of professional activities. A participant in civic and professional affairs of the Zanesville community, he is a former president of the Muskingum County Academy of Medicine, a past-president of the Zanesville Rotary Club, a vestryman in the Episcopal Church and a trustee of the YMCA. In 1953 he was chairman of the campaign that raised $1,500,000 for Good Samaritan Hospital in Zanesville. He also has served as vice-president of the Board of Trustees of Muskingum College, New Concord, and as a member of the Ohio Wesleyan Associates. He is a member of Nu Sigma Nu, Phi Gamma Delta, various Masonic bodies and the Elks Lodge.



ROBERT S. MARTIN, M.D.

Dr. Martin also is a member of the Board of Governors of the American College of Surgeons, being one of three members representing the Section on Otorhinolaryngology of the American Medical Association.

A native of Shelby County, Dr. Martin received his M. D. degree from the University of Cincinnati College of Medicine in 1919, then went west for his internship and early practice. His internship was at Creighton Memorial Hospital in Omaha, Nebraska, upon completion of which he did general practice work in Red Cloud, Nebraska, until 1930. He opened his eye, ear, nose and throat practice in Zanesville after taking postgraduate work at the New York Eye and Ear Infirmary.

Dr. Martin served four years as Councilor from the Eighth District before he was named President-Elect last year. Dr. and Mrs. Martin are the parents of a married daughter.

SECOND DISTRICT COUNCILOR

The House of Delegates elected Dr. R. Dean Dooley, Dayton, as Councilor for the Second District to succeed Dr. Woodhouse.

Dr. Dooley's role as a practicing physician in Dayton began in 1924 when he became an intern and later resident at Miami Valley Hospital, after graduation from the University of Cincinnati College of Medicine. He first entered practice as a surgeon in association with the late Drs. L. G. Bowers and Elmer Arn, but found general practicing more to his liking. Since the early 40's his practice has been limited to obstetrics.



R. DEAN DOOLEY, M.D.

Dr. Dooley's activities in behalf of medical association work are extensive. In the Montgomery County Medical Society he has served on many committees; was chairman of the first Mediation Committee; is current President of the local Society. On the state level he has been secretary and then chairman of the OSMA Section on Obstetrics and Gynecology and a delegate from Montgomery County for 18 consecutive years. He has served as chairman of the OSMA committee on Judicial and Professional Relations and is a member of the Board and of the Executive Committee of Ohio Medical Indemnity, Inc., and a member of the Board of Directors of the Southwestern Ohio Blue Cross.

He has served on the obstetrical staff of the Miami Valley Hospital continuously for 25 years and has been a member of the senior attending staff for 14 years. He has served six years on the Board of Trustees of Miami Valley Hospital during the time the expansion program resulted in the new building.

Dr. Dooley is a member of Delta Tau Delta Fraternity and Alpha Omega Alpha Honorary Medical Fraternity. He is married and has two sons and four grandchildren.

Dr. Dooley was born in Grant County, Indiana, and received his primary education in the traditional one-room school house typical of that era. He graduated from Marion (Indiana) High School in 1916 and entered De Pauw University for premedical study. World War I interrupted his college work by service in the 42nd Rainbow Division. The war ended, he resumed his studies at the Lewis Institute, Chicago, after which he entered University of Illinois Medical School, trans-

fering later to the University of Cincinnati where he received his M. D. degree.

Dr. Dooley is a member of Delta Tau Delta Fraternity and Alpha Omega Alpha Honorary Medical Fraternity. He is married and has two sons and four grandchildren. A glimpse into his personal life was afforded recently in a feature article published by the *Dayton Daily News*. "Dooleyland," as the news reporter calls his display of miniatures created for the grandchildren, recreates such bygone relics as the gristmill and blacksmith shop of the past century. It combines Dr. Dooley's two hobbies of woodworking and Civil War history.

PAST-PRESIDENT

Dr. Richard L. Meiling, Columbus, as immediate Past-President will serve an additional year on The Council.

TREASURER

Dr. Geo. J. Hamwi, Columbus, is in the midst of a two-year term as Treasurer. He was elected last year to serve the remaining two years of the unexpired term of Dr. Meiling.

COUNCILORS RE-ELECTED

The following Councilors were elected for additional two-year terms:

Dr. Frank H. Mayfield, Cincinnati, was elected by the House of Delegates to fill the remaining year of the unexpired term of Dr. Charles T. Atkinson, of Middletown. Dr. Mayfield was named by The Council last year to serve as First District Councilor until the House of Delegates met. Dr. Atkinson resigned because of illness.

Dr. Paul F. Orr, Perrysburg, was re-elected Councilor of the Fourth District. Dr. Orr was elected to that office in 1953 and re-elected in 1955.

Dr. Carl A. Gustafson, Youngstown, was re-elected Councilor of the Sixth District. Dr. Gustafson was elected to that office in 1952 to fill one year of an unexpired term and was re-elected in 1953 and 1955.

Dr. William D. Monger, Lancaster, was elected to his first full term as Councilor of the Eighth District. Dr. Monger was elected in 1956 to fill one year of the unexpired term of Dr. Martin.

Dr. Edwin H. Artman, Chillicothe, was re-elected Councilor of the Tenth District. Dr. Artman was elected to that office in 1953 and re-elected in 1955.

Councilors in the midst of two-year terms are: Dr. James R. Jarvis, Van Wert, Third District; Dr. George W. Petznick, Cleveland, Fifth District; Dr. Robert E. Hopkins, Coshocton, Seventh District; Dr. Carter L. Pitcher, Portsmouth, Ninth District, and Dr. H. T. Pease, Wadsworth, Eleventh District.

Internal Revenue Service Rules On Physician's "Earned Income"

In defining what constitutes earned income for purposes of the retirement income limitation provided in the Internal Revenue Code, the Internal Revenue Service has ruled that investment of a physician's capital in office equipment, such as X-ray machines, is not a material income-producing factor, and therefore "the amount of professional fees received shall not be reduced by any expenses connected with the earning of such income" and are considered "earned income" in their entirety.

The ruling stated in part: "A large investment of capital by a doctor, dentist, or other professional taxpayer in office equipment, such as X-ray machines, is not a material income-producing factor in the taxpayer's business; therefore, the amount of professional fees received shall not be reduced by any expenses connected with the earning of such income but are considered 'earned income' in their entirety for the purpose of the limitation in section 37 (d) (2) of the Code."

The ruling also explained that the amount of capital employed is incidental to profits derived from professional fees, the growth of the profession being dependent primarily on the reputation and technical skill of a doctor, dentist or other professional taxpayer, and held that "such capital is not a material income-producing factor in the taxpayer's business. Accordingly, the entire amount received as professional fees, without any reduction for expenses connected with the earning of such income, is considered to be 'earned income' for the purpose of the limitation provided by section 37 (d) (2) of the Code."

AMA Produces New Film To Tell Public What AMA Does

"What doctors do as a group is sometimes more important than what they do individually." These are the words of news commentator John Cameron Swazy in setting the stage in a new AMA film for a series of incidents documenting how organized medicine serves Americans everywhere. Swazy is narrator for this 30-minute color film scheduled for release to medical societies for local showings September 1. The film will be premiered August 28 at AMA's Public Relations Institute in Chicago.

Titled "Whitehall 4-1500," the film tells the story behind this phone number, which puts a caller in touch with America's physicians as a group—the American Medical Association headquarters in Chicago. Dramatic, short sequences show how AMA in action helps save youngsters' lives through poison control activities, helps reduce highway deaths, helps place physicians in isolated areas, helps make jobs safer for industrial workers and life better for everyone. It reveals the story of AMA efforts to solve many current health problems.

Annual Meeting in Review . . .

Awards Are Announced for Outstanding Exhibits; Also Some Highlights And Sidelights of the Many Happenings During the Columbus Meeting

IN this issue of *The Journal* are the official reports of proceedings at the 1957 Annual Meeting, arranged under various headings. The reader is referred to the index and to the various articles for details. Throughout these reports are picture layout pages which also tell graphically the story of what took place, with some interesting sidelights.

Here also is some additional information:

SCIENTIFIC AND EDUCATIONAL EXHIBIT

One of the main features of the Annual Meeting was the display of Scientific and Educational Exhibits, with its excellent setting in the Exhibition Hall of the Veterans Memorial Building.

A special committee was appointed to judge the Scientific Exhibits and to offer appropriation recognition for outstanding displays. Selections were made in the fields of teaching, original investigation, and in the special exhibits category. The following selections were announced:

Gold Award in Teaching Field—The exhibit, "Differential Diagnosis and Management of the Red Eye," sponsored by Dr. William H. Havener, Department of Ophthalmology, Ohio State University College of Medicine.

Gold Award in Original Investigation—The exhibit, "The Relationship of Hydrocephalus to Myelomenigocele and Hydromyella," sponsored by Dr. W. James Gardner and Dr. Jorge Angel, Cleveland Clinic Foundation.

Silver Award in Teaching Field—The joint exhibits, "Obliterative Arterial Disease of the Lower Extremity," and "Ulcers of the Legs Due to Venous Insufficiency," sponsored by Dr. John J. Cranley and Dr. Raymond J. Krause, Cincinnati.

Silver Award in Original Investigation—The exhibit, "Cytology in Diagnosis and Research," sponsored by the following team from the Department of Pathology, Ohio State University: Drs. Emmerich von Haam, G. Ceelen, D. Scarpelli, A. Horva, C. Gantt, M. S. N. Murphy, and E. Miller.

Bronze Award in Teaching Field—The exhibit, "Fractures of the Calcaneus," sponsored by Drs. Arnold D. Piatt, Gerald A. Erhard, and William V. Banning, of Newark.

Bronze Award in Original Investigation—The exhibit, "Transcarotid Aortography," sponsored by Drs. William Molnar, Joseph M. Ryan, Karl P. Klassen and Sidney W. Nelson, Ohio State University Health Center.

A special award was presented to the Montgomery County Medical Society for its two exhibits "Montgomery County Society for Cancer Control," and "The Homograft Bank—A Community Function."

Certificates of Merit were awarded the American Medical Association and the National Safety Council, joint sponsors of the exhibit, "Alcohol Tests for Drinking Drivers."

TECHNICAL EXHIBIT

Another outstanding feature of the Annual Meeting was the Technical Exhibit. Representatives of pharmaceutical and other supply firms had this opportunity to meet physicians face to face and present the latest developments in their respective fields. Physicians also welcomed the opportunity—as indicated by the attendance in the exhibits—of chatting with their detail men.

NEW LOCALE

This is the first year that the new Veterans Memorial Building in Columbus was available for the Annual Meeting. This new auditorium with its spacious exhibit space and other facilities turned out to be a welcome cover for an all-inclusive program.

PUBLIC RELATIONS

Press, radio and television media throughout Ohio gave widespread publicity to the annual meeting, in advance, during and following the sessions. For example, some 150 newspapers published all or parts of an advance release prepared by the OSMA headquarters staff.

News media representatives were assisted continuously by the staff during the meeting, and a news room was at their disposal in the Veterans Memorial Building. News media personnel who "covered" the sessions represented the Associated Press, United Press, International News Service, *The Columbus Dispatch*, *The* (Columbus) *Ohio State Journal*, Columbus television station WBNS-TV, *The Cleveland Press*, *The Toledo Blade* and *The Columbus Citizen*.

1958 MEETING IN CINCINNATI

The 1958 Annual Meeting of the Association will be held in Cincinnati with the Netherland-Hilton Hotel as headquarters, April 15-17.

COMMITTEE MEMBERS NAMED

A new roster of the standing committees and special committees of the Association is contained in this issue starting on page 743. Following this roster is a list of officers of County Medical Societies with meeting dates; also the names of the state officers of the Woman's Auxiliary.

House of Delegates . . .

Twenty-Three Resolutions Acted Upon at 1957 Annual Session in Columbus: Officers, Councilors and AMA Delegates Are Elected

MINUTES OF FIRST SESSION

THE first session of the House of Delegates of the 1957 Annual Meeting of the Ohio State Medical Association was held in the Grand Ballroom, Neil House, Columbus, on Monday evening, May 13. There was a dinner with a business session following.

The business session was called to order by Dr. Norman O. Rothermich, President of the Columbus Academy of Medicine, who, after welcoming the delegates, introduced the President, Dr. Richard L. Meiling, Columbus.

Dr. Meiling called upon Dr. R. L. Rutledge, Alliance, chairman of the Committee on Credentials, for a report. **Dr. Rutledge reported that 134 delegates had checked in and were seated;** that 13 alternates and 20 guests also were in attendance.

Dr. Meiling introduced the President-Elect, Dr. Robert S. Martin, Zanesville. Dr. Martin turned the meeting back to Dr. Meiling, who then delivered his presidential address. **(See pages 799-805 in this issue for Dr. Meiling's address.)**

GUESTS INTRODUCED

Following his address, Dr. Meiling introduced Dr. E. G. Shelley, North East, Pennsylvania, President of the Medical Society of the State of Pennsylvania. Dr. Shelley was given an ovation and he addressed the House of Delegates. Mr. Earl Morris, Columbus, President of the Ohio State Bar Association and a long time personal friend of Dr. Meiling, was presented to the House of Delegates and he spoke briefly. Dr. Meiling also presented to the House of Delegates Mr. Joseph Sabino, Columbus, President of the Ohio State Pharmaceutical Association. Mr. Sabino made a short talk. Mr. Harry Eader, Columbus, Executive Secretary of the Ohio Hospital Association, was introduced, as were Mr. Robert E. Rakel, Cincinnati, President of the Student American Medical Association Chapter, University of Cincinnati College of Medicine, and national President of the Student A. M. A.; and Mr. Peter Cuppage, Columbus, President of the Student American Medical Association Chapter, Ohio State University College of Medecine.

On motion duly made, seconded and carried, the minutes of the meetings of the House of Delegates held in connection with the 1956 Annual Meeting in Cleveland were approved as published in The Ohio State Medical Journal.

REFERENCE COMMITTEES

President Meiling then appointed the following reference committees:

Credentials of Delegates—R. L. Rutledge, Alliance, chairman; B. C. Diefenbach, Martins Ferry; Sol Maggied, West Jefferson.

President's Address—Mel A. Davis, Columbus, chairman; Ralph W. Holmes, Chillicothe; J. Lester Kobacker, Toledo; Paul J. Schildt, Cleveland; M. D. Shilling, Ashland.

Resolutions Committee No. 1—Edmond K. Yantes, Wilmington, chairman; George A. Boon, Oak Harbor; John H. Budd, Cleveland; H. D. Chamberlain, McArthur; Donald W. English, Lima; John A. Fraser, East Liverpool; Carl F. Goll, Steubenville; Robert M. Inglis, Columbus; Maurice M. Kane, Greenville; E. J. Meckstroth, Sandusky; A. C. Ormond, Zanesville.

Resolutions Committee No. 2—R. Dean Dooley, Dayton, chairman; Robert S. Caulkins, Jr., Delaware; Floyd M. Elliott, Ada; J. Robert Hudson, Cincinnati; H. C. Knierim, Mansfield; Donald I. Minnig, Akron; Benjamin S. Park, Painesville; R. G. Plummer, Newark; Frank F. A. Rawling, Toledo; George N. Spears, Ironton; Norman L. Wright, Coshocton.

Tellers and Judges of Election—Asher Randell, Youngstown, chairman; Fred P. Berlin, Lima; J. Martin Byers, Greenfield; J. Harold Kotte, Cincinnati; M. H. Lambright, Jr., Cleveland; Chester P. Swett, Lancaster.

NOMINATING COMMITTEE CHOSEN

The House of Delegates then elected the following Committee on Nominations:

First District—Harry K. Hines, Cincinnati, temporary chairman.
Second District—Kenneth D. Arn, Dayton.
Third District—Floyd M. Elliott, Ada.
Fourth District—Frank F. A. Rawling, Toledo.
Fifth District—Harry A. Haller, Cleveland.
Sixth District—Donald I. Minnig, Akron.
Seventh District—Glenn C. Dowell, Carrollton.
Eighth District—James A. L. Toland, Cambridge.
Ninth District—John J. Schwab, Gallipolis.
Tenth District—Ralph W. Holmes, Chillicothe.
Eleventh District—O. J. Nicholson, Norwalk.

RESOLUTIONS INTRODUCED

The next order of business was the introduction of resolutions. Twenty-three resolutions were presented and automatically referred to the Ref-

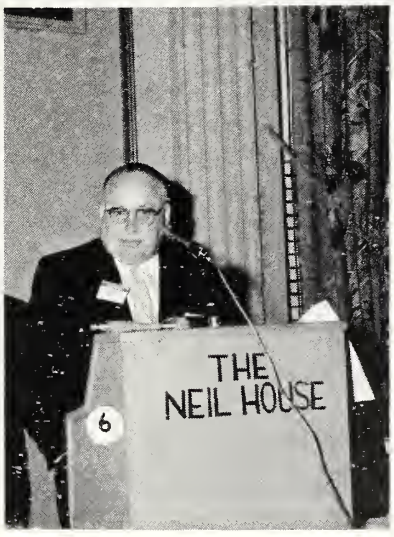














Action Pictures of the House of Delegates

1. A general view of the House in action.

2. Retiring-President Meiling, Incoming-President Martin and President-Elect Woodhouse.

3. Dr. E. G. Shelley, President of the Pennsylvania State Medical Association, brings greetings from the neighboring state.

4. Dr. Yantes, chairman of Resolutions Committee No. 1, reports.

5. The Hon. Harold Oyster, Representative of Washington County, is a guest of the House of Delegates. Mr. Oyster was author of the OSMA-sponsored H. B. 384. He was chairman of the House Health Committee.

6. Dr. Dooley here reports as chairman of Resolutions Committee No. 2. Later he was named Councilor of the Second District.

7. Dr. Dale Hudson, of Miami County, nominates Dr. Woodhouse as President-Elect.

erence Committees on Resolutions. (See minutes of Second Session of the House of Delegates for text of resolutions as introduced and actions thereon.)

Following announcements regarding the Annual Meeting program and announcements as to where the various reference committees would meet, the House of Delegates recessed until Thursday noon, May 16, for its second and final business session.

MINUTES OF SECOND SESSION

The second and final session of the House of Delegates at the 1957 Annual Meeting of the Ohio State Medical Association was held Thursday afternoon, May 16, in the Grand Ballroom, Neil House, Columbus, following a luncheon.

The chairman of the Committee on Credentials, Dr. R. L. Rutledge, Alliance, reported that 145 delegates had signed in and were seated and that in addition 22 guests were in attendance.

TALK BY REPRESENTATIVE OYSTER

Before starting the business session Dr. Meiling introduced State Representative Harold W. Oyster, Marietta, chairman of the House Health Committee and sponsor of House Bill 384, the controversial bill to make more dogs available for medical research and teaching institutions. Mr. Oyster was given a great ovation. He addressed the House briefly, emphasizing the importance of more active participation in civic, legislative and political affairs by physicians and other professional men.

President Meiling then introduced Mr. J. Richard Baringer, Cleveland, representing the Student A. M. A. Chapter at Western Reserve University Medical School.

COMMITTEE ON PRESIDENT'S ADDRESS

The next order of business was the report of the Reference Committee on President's Address. This report was presented by Dr. Mel A. Davis, Columbus, chairman of that committee, on behalf of the committee, the other members of which were: Dr. Ralph W. Holmes, Chillicothe; Dr. J. Lester Kobacker, Toledo; Dr. Paul J. Schildt, Cleveland; Dr. M. D. Shilling, Ashland. The report of the reference committee, reading as follows, was approved on motion duly made, seconded and carried:

"In behalf of the members of the House of Delegates and the Ohio State Medical Association, the Reference Committee on the President's Address wishes to commend Doctor Meiling for his excellent scholarly and educational address. It is obvious that considerable time, research and thought were necessary for its preparation.

"We congratulate Doctor Meiling and The Council on the wisdom of their present basic philosophy. We endorse and wholeheartedly support the reiterated concept that 'The Ohio State Medical Association has neither the legal nor moral right to contract the professional services of the individual members nor to fix professional fees.'

"We agree with Doctor Meiling that indemnity type medical care programs serve both the public and the physician best and that it is not in the best interests of the patient care when a disinterested third party attempts to fix fees, whether that third party be government, labor, management or insurance interests.

"We wish to further commend Doctor Meiling for well conceived plans

"1. For proposing a permanent home for the Ohio State Medical Association with its many auxiliary services.

"2. For fostering mutual understanding and a basis for cooperation between the Ohio State Bar Association and the Ohio State Medical Association.

"3. For recommending state-wide programs in the broad aspects of rehabilitation.

"4. For requesting the preparation of an official volume of the 'History and Development of Medicine and its Organization in the State of Ohio.' We strongly urge The Council to grant this request so that the wealth of our heritage may be readily available in a single location.

"With Doctor Meiling we, too, pray to be blessed with the strength and understanding necessary to meet the complexities of the problems confronting our colleagues, our patients and our fellow citizens to the end that we may serve humanity in a manner befitting our dedicated medical profession."

ACTION ON RESOLUTIONS

Reports of the two reference committees on resolutions were called for.

Dr. Edmond K. Yantes, Wilmington, reported for Resolutions Committee No. 1. His report was distributed to members of the House of Delegates for the members to follow as the report was read.

RESOLUTION A AND RESOLUTION L

The committee reported first on Resolution A, introduced by Dr. Charles W. Pavey, Columbus, and Resolution L, introduced by Dr. John B. Hazzard, Cleveland, each reading as follows:

RESOLUTION A

WHEREAS, The Medicare Program as it is presently operating constitutes a government-paid, service-type insurance plan and

WHEREAS, The Ohio State Medical Association has on at least one previous occasion rejected as unsound and inimical to the private practice of medicine such service plan insurance and

WHEREAS, The continued operation of Medicare on this basis together with its inevitable expansion will constitute a certain entering wedge for the socialization of the practice of medicine, now

THEREFORE BE IT RESOLVED, That the

(Continued on Page 814)















Scenes Snapped at the Annual Banquet

1. Among members of The Council and their ladies, left to right, Dr. and Mrs. Woodhouse, Dr. and Mrs. Orr and Dr. and Mrs. Jarvis.

2. Honored guests at the Banquet were Governor and Mrs. C. William O'Neill, shown at left and right; center are Dr. and Mrs. Meiling.

3. Dr. and Mrs. Petznick.

4. Dr. and Mrs. Hamwi and Dr. and Mrs. Artman.

5. Dr. and Mrs. Pease

6. Governor O'Neill addresses members and guests at the Banquet.

7. Mrs. Robert Flanders, President of the Woman's Auxiliary to the AMA at the Banquet, and Dr. Edward J. McCormick, Past-President of the OSMA and the AMA.

House of Delegates of the Ohio State Medical Association indicate its strong disapproval of the operation of Medicare on a service basis and

BE IT FURTHER RESOLVED, That we instruct the Ohio Delegates to the American Medical Association to introduce a similar resolution at the next meeting of the American Medical Association House of Delegates and incorporating a request that the executive officers of the American Medical Association take whatever steps might be helpful in getting "Medicare" changed to an indemnification type of insurance.

RESOLUTION L

WHEREAS, The Council of the Ohio State Medical Association in recognition of the medical practice controls of Public Law #569, 84th Congress, refused to sign a contract which would limit the time honored patient-doctor relationship, and

WHEREAS, This action and similar action by the Medical Association of Rhode Island was unique among the forty-eight states,

THEREFORE BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association commend The Council of the Ohio State Medical Association for this forthright action, and

BE IT FURTHER RESOLVED, That the delegates from the Ohio State Medical Association to the American Medical Association be instructed to introduce a resolution at the next regular meeting of the House of Delegates of the American Medical Association, requesting that responsible officials of the American Medical Association take whatever steps are necessary to secure modification of Public Law #569, 84th Congress, so that it will provide indemnification of servicemen for medical services for their dependents in place of the present service-type plan.

Dr. Yantes reported that his committee had considered the resolutions jointly because they were of similar content. He stated that the committee recommended that Resolution A be tabled and that Resolution L, with a substitute final paragraph be approved. Resolution L, as amended, would then read as follows:

AMENDED RESOLUTION L

WHEREAS, The Council of the Ohio State Medical Association in recognition of the medical practice controls of Public Law #569, 84th Congress, refused to sign a contract which would limit the time honored patient-doctor relationship, and

WHEREAS, This action and similar action by the Medical Association of Rhode Island was unique among the forty-eight states,

THEREFORE BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association commend The Council of the Ohio State Medical Association for this forthright action, and

BE IT FURTHER RESOLVED, That the delegates from the Ohio State Medical Association to the American Medical Association be instructed to introduce a resolution at the next regular meeting of the House of Delegates of the American Medical Association, requesting that responsible officials of that organization take whatever steps are necessary to secure modification of Public Law #569, 84th Congress, so that it will provide an indemnity type program.

On motion by Dr. Yantes, seconded and carried, the committee's recommendations regarding Resolution L and Resolution A were adopted, meaning that Amended Resolution L was approved.

RESOLUTION H AND RESOLUTION P

The next resolutions considered by the committee were Resolution H, introduced by Dr. Charles W. Hoyt, Cincinnati, and Resolution P, introduced by Dr. John A. Kenney, Jr., Cleveland, reading as follows:

RESOLUTION H

WHEREAS, There have been continued increases in professional liability or malpractice insurance without accurate statistics being presented for loss ratio experience in the State of Ohio;

BE IT RESOLVED, That the Ohio State Medical Association file a protest under RC 3937.04 if and when the National Bureau of Casualty Underwriters file petitions for further increases of professional liability or malpractice insurance rates.

RESOLUTION P

WHEREAS, There has been mounting concern regarding recent increases in premium rates for malpractice insurance, and

WHEREAS, In 1954 the Florida Medical Association successfully requested that their insurance commissioner hold a public hearing on a proposed premium rate increase which resulted in the withdrawal of the proposed increase

THEREFORE BE IT RESOLVED, That the Headquarters Office of the Ohio State Medical Association anticipate the next proposed increase in premium rates for malpractice insurance in Ohio, and

BE IT FURTHER RESOLVED, That the Insurance Commissioner be requested to hold a public hearing on the proposed increase to see if it can be demonstrated whether or not such an increase is necessary and justified.

Dr. Yantes stated that his committee had considered Resolution H and Resolution P jointly as both resolutions dealt with the subject of malpractice. He reported that this committee recommends that Resolution P be laid on the table and that a Substitute Resolution H, reading as follows, be adopted:

SUBSTITUTE RESOLUTION H

"WHEREAS, There have been continued increases in professional liability or malpractice insurance without accurate statistics being presented for loss ratio experience in the State of Ohio;

"BE IT RESOLVED, That the Ohio State Medical Association file a protest under RC 3937.04 if and when underwriters file petitions for further increases of professional liability or malpractice insurance rates;

"BE IT FURTHER RESOLVED, That the Insurance Commissioner be requested to hold a public hearing on the proposed increases."

On motion of Dr. Yantes, seconded and carried, the committee's recommendation regarding Resolution P and Substitute Resolution H was

adopted, meaning that Sub. Resolution H was approved.

RESOLUTION J

Dr. Yantes then reported that his committee recommends the adoption of Resolution J, introduced by Dr. Charles W. Hoyt, Cincinnati. The recommendation of the committee approving Resolution J, which reads as follows, was adopted:

WHEREAS, It is often difficult for delegates to fully understand the intent and meaning of resolutions because of the time element that is always present at Ohio State Medical Association annual conventions,

BE IT RESOLVED, That a committee be appointed by appropriate authorities to study the presentation, referral, discussion and consideration of resolutions in order to make recommendations for better and more effective procedure.

RESOLUTION R AND RESOLUTION T

Dr. Yantes' committee reported it had jointly considered Resolution R, introduced by Dr. R. E. Tschantz, Canton, and Resolution T, introduced by Dr. Asher Randell, Youngstown, reading as follows:

RESOLUTION R

WHEREAS, The Ohio State Medical Association has authorized each county society to administer the Salk and other immunization procedures as the component society so decided; and

WHEREAS, This procedure resulted in many types of divergent plans in the state, resulting in much confusion and unfavorable publicity for some of the county societies; and

WHEREAS, Certain national organizations are entering more and more into the fields of medicine and offering free medicines, vaccines, and attempting to set up nationally, immunization programs other than suitable for local county medical societies;

THEREFORE BE IT RESOLVED, That the Stark County Medical Society recommend to the Ohio State Medical Association and to the American Medical Association that these Associations carefully review their position in approving administration by Boards of Health, medical departments of School Boards, Hospitals, manufacturing companies, labor organizations, etc., of mass inoculation procedures except in epidemics or for indigent programs and approve of these procedures in the private doctor's office or facilities directly under his control and oppose any attempt at regimentation of immunization procedures at the local level which interferes with free enterprise.

RESOLUTION T

WHEREAS, It has been the duty and privilege of the medical profession to provide medical attention to the indigent in our communities, and

WHEREAS, There is a bill before the Ohio State Legislature (HB 912) providing for city and general health districts to administer Salk Poliomyelitis vaccine to all persons under 19 years of age without cost, and

WHEREAS, Increasing numbers of organizations are fostering group examination and/or treatments of their employees or members, thereby denying the time-honored physician-patient relationship and free choice of physician.

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association approve the continuance of the administering to the indigent as in the past, and

FURTHER RESOLVED, That the Ohio State Medical Association strongly oppose HB 912 and any legislation of similar nature, and

FURTHER RESOLVED, That the Ohio State Medical Association oppose all forms of group examinations and/or treatments either by management or labor organizations and strongly recommend that said examinations in the physician's office, to continue physician-patient relationships at its high standards, and

FURTHER RESOLVED, That the delegates of the Mahoning County Medical Society attending the Annual Assembly of the Ohio State Medical Association in Columbus, May 14-16, be instructed to present this resolution for the approval of the House of Delegates of the Ohio State Medical Association.

Dr. Yantes reported that the committee recommended that Resolution T NOT be adopted, inasmuch as The Council already had placed the Ohio State Medical Association on record as opposed to House Bill 912.

On motion by Dr. Yantes, seconded and carried, the committee's recommendation with respect to Resolution T was adopted and the resolution was tabled.

Dr. Yantes stated that his committee had redrafted Resolution R into a substitute resolution, reading as follows, and recommends its adoption:

SUBSTITUTE RESOLUTION R

"WHEREAS, The Ohio State Medical Association is of the opinion that each county society should carry out immunization procedures that seem more effective for the area concerned, in the best interests of the community, and

"WHEREAS, Personal health is the responsibility of each individual, and

"WHEREAS, The state of emergency has ceased to exist, and

"WHEREAS, Certain national organizations are entering more and more into the field of medicine and offering free medicines, vaccines, and attempting to set up nationally, immunization programs other than suitable for local community conditions,

"THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association oppose mass inoculation procedures, except in epidemics or emergencies or for indigent programs, and approve of these procedures in the private doctor's office or facilities directly under his control, and

"BE IT FURTHER RESOLVED, That each county medical society re-affirm its continuing program of public education as to the value of immunization procedures relating to all diseases."

On motion duly made, seconded and carried, the recommendation of the committee, that Substitute Resolution R be adopted, was adopted and Sub. Resolution R was approved.

RESOLUTION D

Dr. Yantes reported that the committee had given prolonged consideration to Resolution D, introduced by Dr. T. L. Light, Dayton, and reading as follows:

WHEREAS, Single disease health agencies em-

phasize the great emotional appeal of certain diseases and thus tend to distort their true relation to total health; and

WHEREAS, Doctors of Medicine, in the final analysis, are responsible for the health of the nation and any voluntary health agency expenditure or health agency fund raising campaign that is not in conformity with the prevailing policy of their Medical Society can be detrimental to the total good; therefore,

RESOLVED, First, That the O. S. M. A. House of Delegates approve in principle the formation of a federation at the local level embracing all voluntary health agencies and the raising of funds for the federation through a single drive; and

RESOLVED, Second, That the O. S. M. A. Special Committee on Relationship Between Medical Societies and Voluntary Health Organizations be directed (a) to prepare recommendations for the achievement of a federation of health agencies supported through a single fund drive within the component counties and (b) to present these recommendations to the component County Societies prior to the 1958 Annual Meeting of the Ohio State Medical Association.

SUBSTITUTE RESOLUTION D

Reporting for the committee, Dr. Yantes stated that the committee had drafted a Substitute Resolution D and recommends its adoption. The substitute resolution reads as follows:

"WHEREAS, Single disease health agencies emphasize the great emotional appeal of certain diseases and thus tend to distort their true relation to total health, and

"WHEREAS, Doctors of medicine, in the final analysis, are responsible for the health of the nation and any voluntary health agency expenditure or health agency fund-raising campaign that is not in conformity with the prevailing policy of their medical society can be detrimental to the total good, and

"WHEREAS, Several communities have already organized a federated health drive, therefore

"BE IT RESOLVED, First that the Ohio State Medical Association House of Delegates approve in principle the formation of a federation at the local level embracing all voluntary health agencies and the raising of funds for such federation through a single drive; and

"Second, that the Ohio State Medical Association's special committee on Relationship Between Medical Societies and Voluntary Health Organizations be urged to prepare recommendations which might assist component county medical societies in achievement of such federation, if there exists a desire on the part of lay and physician-citizens of the county for such federation."

Dr. Yantes moved that the recommendation of the committee be adopted and the motion was duly seconded. Dr. Frank F. A. Rawling, Toledo, moved to strike out the first sentence after the words "BE IT RESOLVED" in the substitute resolution. The motion to amend was seconded. There was a discussion by numerous delegates. The motion to amend Substitute Resolution D was defeated. **The motion by Dr. Yantes approving the recommendation of the committee, that Substitute Resolution D be adopted, was adopted and Sub. Resolution D was approved.**

RESOLUTION S

The next resolution considered by the committee was Resolution S, introduced by Dr. R. E. Tschantz, Canton. It read as follows:

WHEREAS, In recent years there has been a tremendous increase in organizations to raise funds for medical research and care of patients with specific diseases.

WHEREAS, Much of the money so raised of necessity is used for administration and fund raising purposes

WHEREAS, There is a rapidly increasing infringement by these organizations on the private practice of medicine

WHEREAS, Many important diseases are being relegated to a secondary role because of a lack of research funds

WHEREAS, There is a constantly increasing demand for federal funds for medical research and hence inevitable federal control of medical research

WHEREAS, Each community should be responsible for the care of all indigents regardless of the disease from which they may be suffering

THEREFORE BE IT RESOLVED:

1. All indigent patients regardless of their disease be cared for only by local government funds and funds provided by local private sources such as Community Funds, United Funds, and like charitable organizations.

2. That the Ohio State Medical Association approve:

a. The establishment of a single national medical research fund to finance medical research into all diseases.

b. Such national medical research fund to be controlled by physicians.

c. Such national research fund to be raised by contributions partially from physicians, but chiefly from United Funds or similar charitable organizations throughout the entire United States.

3. That the Ohio State Medical Association instruct its representatives in the House of Delegates of the American Medical Association to expend every effort to assure the passage of the same resolution by the House of Delegates of the American Medical Association.

4. That the AMA upon passage of this resolution take immediate steps in the establishment of this national medical research fund.

SUBSTITUTE RESOLUTION S

Dr. Yantes stated that his committee had given long and serious consideration to this resolution and had redrafted it into a Substitute Resolution S, reading as follows, and carrying the recommendation of the committee that it be adopted:

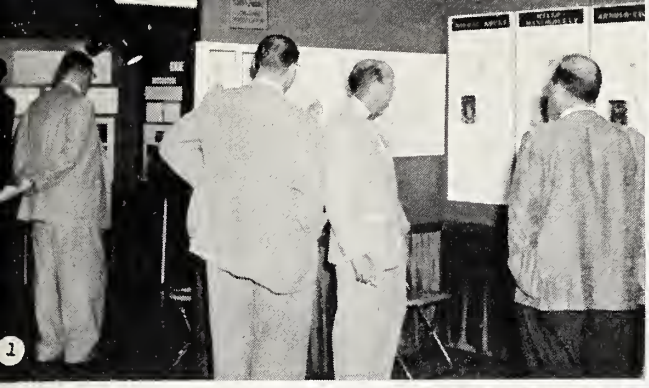
"WHEREAS, In recent years there has been a tremendous increase in organizations to raise funds for medical research and care of patients with specific diseases, and

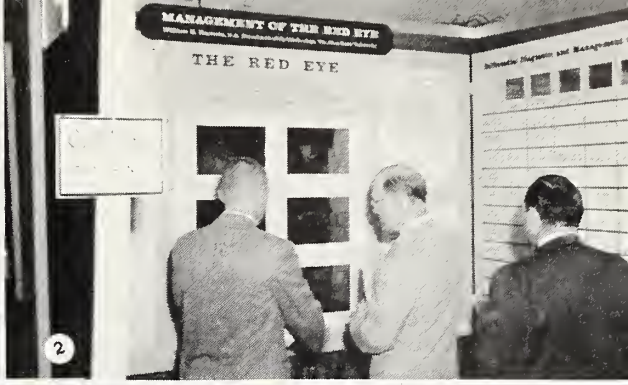
"WHEREAS, Too much of the money so raised of necessity is used for administration and fund-raising purposes, due to multiplicity of costs and unavoidable factors, and

"WHEREAS, Many important diseases are being relegated to a secondary role because of a lack of research funds

"WHEREAS, There is a constantly increasing demand for Federal funds for medical research

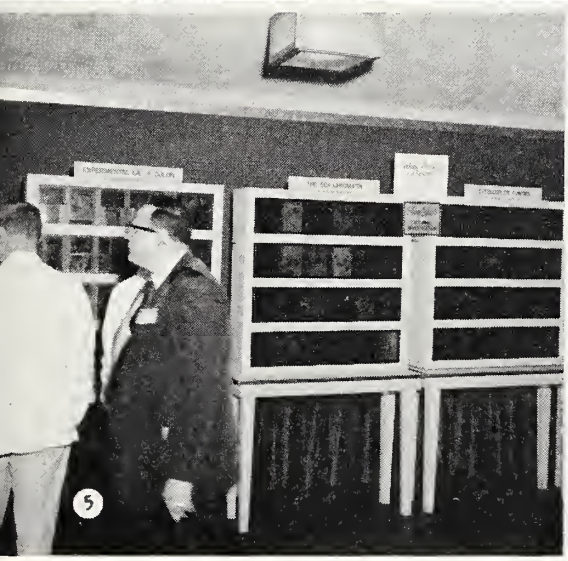
(Continued on Page 818)













Among Winners In Scientific Exhibits

1. Gold Award winner in field of original investigation by Gardner and Angel, Cleveland.

2. Gold Award winner in teaching field by Havener, Dept. of Ophthalmology, Ohio State University.

3. "Transcarotid Aortography" exhibit sponsored by an OSU Health Center team.

4. Bronze Award winner in teaching field sponsored by Dr. Piatt and associates of Newark.

5. The exhibit sponsored by the Department of Pathology, Ohio State University, winner of Silver Award in original investigation.

6. A Certificate of Merit went to this AMA exhibit on "Alcohol Tests for Drinking Drivers."

(See text of story for details on Exhibits.)

and hence inevitable Federal control of medical research

"WHEREAS, Each community should be responsible for the care of all indigents regardless of the disease from which they may be suffering

"THEREFORE, BE IT RESOLVED, 1. All indigent patients regardless of their disease be cared for only by local government funds and funds provided by local private sources such as Community Funds, United Funds, and like charitable organizations and by local physicians.

"2. That the Ohio State Medical Association approve:

"a. The establishment of a single national medical research fund to finance medical research into all diseases.

"b. Such national medical research fund to be controlled by physicians.

"c. Such national research fund to be raised by contributions from United Funds or similar charitable organizations and physicians throughout the entire United States.

"3. That the Ohio State Medical Association instruct its representatives in the House of Delegates of the American Medical Association to expend every effort to assure the passage of the same resolution by the House of Delegates of the American Medical Association.

"4. That the AMA upon passage of this resolution take immediate steps in the establishment of this national medical research fund."

During the discussion a motion was made by Dr. H. A. Haller, Cleveland, and seconded that the word "controlled" in paragraph (b) be changed to "administered." **This motion was adopted.**

Dr. James R. Jarvis, Van Wert, moved that the Substitute Resolution S be amended by striking out the "WHEREAS" immediately preceding the paragraph reading "THEREFORE, BE IT RESOLVED," and that No. 1 following the words "THEREFORE, BE IT RESOLVED" be eleminated. Following a discussion and the defeat of a motion to leave the "WHEREAS" in the resolution, **the motion to amend by Dr. Jarvis was adopted. The motion by Dr. Yantes then was adopted and Sub. Resolution S, as amended and reading as follows, was approved:**

AMENDED SUBSTITUTE RESOLUTION S

"WHEREAS, In recent years there has been a tremendous increase in organization to raise funds for medical research and care of patients with specific diseases, and

"WHEREAS, Too much of the money so raised of necessity is used for administration and fund raising purposes, due to multiplicity of costs and unavoidable factors, and

"WHEREAS, Many important diseases are being relegated to a secondary role because of a lack of research funds

"WHEREAS, There is a constantly increasing demand for Federal funds for medical research and hence inevitable Federal control of medical research

"THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association approve:

"a. The establishment of a single national medical research fund to finance medical research into all diseases.

"b. Such national medical research fund to be administered by physicians.

"c. Such national research fund to be raised by contributions from United Funds or similar charitable organizations and physicians throughout the entire United States.

"That the Ohio State Medical Association instruct its representatives in the House of Delegates of the American Medical Association to expend every effort to assure the passage of the same resolution by the House of Delegates of the American Medical Association.

"That the AMA upon passage of this resolution take immediate steps in the establishment of this national medical research fund."

RESOLUTION Q

Dr. Yantes reported that the committee, after considering Resolution Q, introduced by Dr. E. A. Ferreri, Cleveland, concluded that it would not be a practical recommendation and for that reason recommends that Resolution Q, reading as follows, NOT be adopted:

WHEREAS, There is an increased tendency for greater contributions by doctors to hospital building funds for the purpose of increasing hospital bed capacities, and

WHEREAS, These contributions are in reality a professional contribution rather than a personal contribution, and

WHEREAS, The Internal Revenue Service considers such contributions as a personal donation

THEREFORE BE IT RESOLVED, The Ohio State Medical Association delegates to the American Medical Association request the appropriate agents of the American Medical Association to seek to have the Department of Internal Revenue change its ruling in order to make contributions by physicians to hospitals a business rather than personal contribution.

Dr. Yantes then moved that the committee's recommendation in opposition to Resolution Q be adopted and the motion was adopted.

Dr. Yantes then moved the adoption of the report of Resolutions Committee No. 1 as amended. The motion was seconded and carried.

Before retiring Dr. Yantes thanked the members of his committee who had worked faithfully in hearing all witnesses and carefully considering all of the resolutions. Other members of the committee were: George A. Boon, Ottawa County; John H. Budd, Cuyahoga County; H. D. Chamberlain, Vinton County; Donald W. English, Allen County; John A. Fraser, Columbiana County; Carl F. Goll, Jefferson County; Robert M. Inglish, Franklin County; Maurice M. Kane, Darke County; E. J. Meckstroth, Erie County; A. C. Ormond, Muskingum County.

REPORT OF RESOLUTIONS COMMITTEE NO. 2

The next order of business was the report of the Resolutions Committee No. 2. This report was presented by Dr. R. Dean Dooley, Dayton, chairman of the committee.

Dr. Dooley reported that his committee recommends the adoption of Resolution B, introduced by Dr. Charles W. Pavey, Columbus; Resolution E, introduced by Dr. T. L. Light, Dayton; Resolution O, introduced by Dr. Thomas D. Kinney, Cleveland; Resolution I, introduced by Dr. Charles

W. Hoyt, Cincinnati; Resolution W, introduced on behalf of The Council of the Ohio State Medical Association; and Resolution K, introduced by Dr. Charles W. Hoyt, Cincinnati. **The recommendation of the committee, on motion duly made and seconded, that these resolutions be approved, was adopted.** The resolutions, as adopted, read as follows:

RESOLUTION B

WHEREAS, Every session of Congress brings further legislative invasion of the private practice of medicine and

WHEREAS, There is a continuous campaign of propaganda designed to make our citizens amenable to socialism of all varieties and to conceal the true socialistic nature of many legislative proposals and

WHEREAS, The Essay Contest of the Association of American Physicians and Surgeons is one effective method of resisting this indoctrination which is inimical to the economic welfare of our whole country and to the best method of providing medical care for its citizens

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association reaffirm its previous endorsement of the Essay Contest of the Association of American Physicians and Surgeons (Title: The Advantages of Private Medical Care or the Advantages of the American Free Enterprise System); and

BE IT FURTHER RESOLVED, That this contest be recommended to the Woman's Auxiliary of the Ohio State Medical Association and the American Medical Association for sponsorship.

RESOLUTION E

WHEREAS, The present day practice of medicine requires accurate and reliable laboratory procedures, and

WHEREAS, There is at present no effective method of establishing qualifications or standards of diagnostic laboratories, and

WHEREAS, Such criteria are essential to physicians in securing qualified laboratory services for their patients; therefore,

RESOLVED, That The Council of the Ohio State Medical Association appoint a committee to study the matter of establishing qualifications and standards for diagnostic laboratories, this committee to report its recommendations to the 1958 session of House of Delegates.

RESOLUTION O

WHEREAS, Legislation is needed to assure medical research and medical teaching institutions in Ohio of a constant and adequate supply of dogs, so necessary in planning and carrying on vital medical research and medical teaching activities,

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association commends The Council for having sponsored House Bill 384 now pending in the Ohio General Assembly, which, if enacted, would enable Ohio medical research and medical teaching institutions to obtain from Ohio dog pounds, abandoned, unclaimed, unwanted dogs that are now being destroyed, and

BE IT RESOLVED, That members of the medical profession and others interested in seeing that medical research and medical teaching standards in Ohio are maintained and that facilities for medical research and teaching are expanded to meet increasing demands, are urged to strongly recommend to members of the Ohio Senate that they pass House Bill 384, thus following the fine example set by the House of Representatives on May 1.

RESOLUTION I

WHEREAS, There have been controversies in the United States and the State of Ohio on the corporate practice of medicine and,

WHEREAS, The definition of the corporate practice of medicine has not been defined by the Ohio State Medical Association,

BE IT RESOLVED, That the Ohio State Medical Association adopt a definition of the corporate practice of medicine for uniform application throughout the State of Ohio.

RESOLUTION W

BE IT RESOLVED That Section 1 of Chapter 11 of the By-Laws be amended to read as follows:

Section 1. Qualifications for Members in a Component Society: To be eligible for any class of membership in a component society, a physician must possess the qualifications enumerated in Section 4 of Chapter 1 hereof and he must not be engaged, or profess to be engaged, in the practice of sectarian medicine.

To be eligible for active or associate membership in a component society a physician must be a bona fide resident of, or must conduct the major portion of his practice in, the county in which such component society is located; provided, however, that where it is more convenient for a member of a component society to attend the meetings of another component society located in a county adjoining that in which he holds his membership, such member, upon application to, and approval by, both the society in which he holds membership and the society in such adjoining county, shall be entitled to a transfer of his membership to such adjoining component society.

Subject to the provisions of the foregoing paragraphs of this Section 1, each component society shall be the sole judge of the qualifications necessary for any and all classes of membership in such society.

BE IT FURTHER RESOLVED That Chapter 11 of the By-Laws be amended by adding thereto the following sections:

Section 6. Disciplinary Action by the Council of the Ohio State Medical Association. Original charges against a member of a component society may be instituted and be heard by The Council of the Ohio State Medical Association in the same manner as provided in Section 4 of this Chapter 11 for disciplinary procedure by a component society; and in any case in which a component society fails to take prompt disciplinary action against one of its members after being requested in writing by the Council of the Ohio State Medical Association to do so, the Council shall proceed to institute and prosecute such disciplinary action and to enter such order of dismissal or censure, or of suspension or expulsion from the component society, as the evidence adduced at the hearing may warrant.

Section 7. Effect of Revocation of License. A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation.

BE IT FURTHER RESOLVED That existing Section 1 of Chapter 11 be and the same hereby is repealed.

RESOLUTION K

WHEREAS, The Academy of Medicine of Cincinnati has taken action on the policies of the Joint Commission on Accreditation of Hospitals

similar to that of the Stover Committee, whose recommendations were adopted by the House of Delegates of the American Medical Association and subsequently presented by the American Medical Association representatives to the Joint Commission for approval and adoption;

BE IT RESOLVED, That the Council of the Ohio State Medical Associaton obtain current information on what measures are being taken to correct certain unnecessary requirements that are enforced within the Commission's framework;

BE IT FURTHER RESOLVED, That such information be published in the Ohio State Medical Journal for the general information of the membership with emphasis on those recommendations made by the Stover Committee which were **not** adopted.

RESOLUTION N

Dr. Dooley reported that his committee also recommended the adoption of Resolution N, introduced by Dr. John B. Hazard, Cleveland. It read as follows:

WHEREAS, The House of Delegates of the American Medical Association has repeatedly condemned the disposition by a physician of his professional services under terms or conditions which permit any corporation, hospital or other lay person to sell his professional services, otherwise known as the corporate practice of medicine, and

WHEREAS, The Committee on Constitution and By-Laws of the American Medical Association has published in *The Journal of the American Medical Association* a proposed revision of the Principles of Ethics (pursuant to direction of the House of Delegates meeting at Seattle in December, 1956, to clarify §6 of said proposed revision as then proposed and to publish the same) and said committee will present to the House of Delegates of the American Medical Association meeting in New York in June, 1957, this proposed revision which includes a §6 as follows:

"§6. A physician should not dispose of his services under terms or conditions which (1) interfere with or impair the free and complete exercise of his independent medical judgment and skill, (2) cause deterioration of the quality of medical care, (3) or permit the exploitation of his services for financial profit." and

WHEREAS, Said proposed revision of §6 is ambiguous and does not appear to condemn the corporate practice of medicine in accordance with the repeated resolutions of the House of Delegates of the American Medical Association; now

THEREFORE BE IT RESOLVED, That §6 of the proposed revision of the Principles of Medical Ethics should be amended to read as follows:

"§6. A physician should not dispose of his services under terms or conditions which (1) interfere with or impair the free and complete exercise of his independent medical judgment and skill, (2) cause deterioration of the quality of medical care, (3) or permit the sale of his professional services by any corporation or other lay person." and, as so amended, adopted by the House of Delegates of the American Medical Association; and

BE IT FURTHER RESOLVED, That the delegates from Ohio to the House of Delegates of the American Medical Association meeting in New York in June, 1957, present the foregoing suggestion to the reference committee of the House of Delegates of the American Medical Association which will have the proposed revision of the Principles of Ethics under consideration and advocate its adoption and present to the House of Delegates of the American Medical Association and urge upon it the adoption of §6 of the proposed revision of the Principles of Ethics in the form above set out in the preceding paragraph.

Dr. Dooley's motion that the recommendation of the committee be adopted was seconded and a discussion ensued. Dr. Pavey moved that (3) of the first "Be It Resolved" of the resolution be changed to read as follows: "or permit the sale of his professional services by any lay person or corporation." **The motion to amend was seconded and adopted. The motion that Resolution N, as amended, be adopted, was adopted.**

RESOLUTION F

Dr. Dooley reported that his committee had considered Resolution F, introduced by Dr. Sol Maggied, West Jefferson, reading as follows:

WHEREAS, There is such an unseemly delay of two to four months between submission of fee-bill and payment of same, and

WHEREAS, When a C-1 (blue) copy is submitted to the Industrial Commission of Ohio all parties concerned, employee, employers, actuaries and physicians receive claim numbers soon after the claim is submitted but,

WHEREAS, When a C-3 (pink) copy is submitted the physician must wait the many weeks described above to know even if his claim is accepted.

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association should endeavor to effect the change by the Industrial Commission of Ohio whereby the attending physician will be sent a card with the claim number as soon as designated for any claim.

The reference committee, Dr. Dooley reported, **recommends the adoption of a Substitute Resolution F, reading as follows:**

SUBSTITUTE RESOLUTION F

"WHEREAS, There is an apparent delay in investigation of questionable claims with the Bureau of Workmen's Compensation.

"WHEREAS, When a C-1 (blue) form is submitted to the Bureau of Workmen's Compensation of Ohio all parties concerned, employee, employers, actuaries and physicians receive claim numbers promptly after the claim is submitted.

"WHEREAS, When a C-3 (pink) form is submitted the physician is not notified of the claim number.

"THEREFORE BE IT RESOLVED, That the Ohio State Medical Association endeavor to effect a change by the Bureau of Workmen's Compensation of the State of Ohio whereby the attending physician will be notified of the claim number without delay."

Dr. Dooley moved the adoption of the recommendation of the reference committee. **Dr. Sol Maggied, West Jefferson, moved and the motion was seconded and carried,** that the word "questionable" be deleted from the first WHEREAS section and that the words "of any and all claim numbers without delay" be inserted for the words "of the claim number without delay" in the final paragraph of the resolution.

Dr. Norman L. Wright, Coshocton, moved and the motion was seconded and carried that the first two WHEREAS sections of the resolution be

(Continued on Page 822)









Additional Scenes at the Annual Banquet

1. Members and guests enjoy dinner and an evening of entertainment.

2. Dr. Charles Hudson, at rostrum, welcomes Dr. Mailing to the role of Past-President, and presents him with a silver tray in appreciation of his year of service as President.

3. New president of the Woman's Auxiliary to the OSMA, Mrs. Frederick, with Dr. Frederick.

4. An evening of entertainment and dancing was enjoyed by all.

eliminated.

On motion by Dr. Dooley, seconded and carried, the recommendation of the committee that Substitute Resolution F, as amended, be approved, was adopted. The amended resolution, as approved, read as follows:

AMENDED SUBSTITUTE RESOLUTION F

"WHEREAS, When a C-3 (pink) form is submitted to the Bureau of Workmen's Compensation, the physician is not notified of the claim number.

"THEREFORE BE IT RESOLVED, That the Ohio State Medical Association endeavor to effect a change by the Bureau of Workmen's Compensation whereby the attending physician will be notified of any and all claim numbers without delay."

RESOLUTION G

In its report concerning Resolution G, introduced by Dr. Sol Maggied, West Jefferson, the committee stated that the resolution is a reaffirmation of the policy of the Ohio State Medical Association Council and that the committee wishes to commend The Council for its stalwart stand on this issue. **The recommendation for approval of Resolution G, reading as follows, was adopted:**

WHEREAS, One aim of this Association is to maintain the doctor-patient relationship in the practice of medicine, and

WHEREAS, There is an increasing trend of socialization of medicine at this time, and

WHEREAS, There is a strongly increasing tendency by adjusting departments of casual insurance companies to ask for adjustments and/or compliance to their fee schedules thereby creating a socialization pattern

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association re-affirm its stand against the socialization of medicine and remind all parties concerned that the insurance company is a third party in the doctor-patient relationship.

RESOLUTION M

Dr. Dooley reported that the committee had considered Resolution M, introduced by Dr. John B. Hazzard, Cleveland, and recommends that the resolution, as amended, be adopted. Dr. Dooley's motion was seconded and carried and Resolution M, with minor amendments by the committee, was adopted, reading as follows:

WHEREAS, An organization known as the American Thrift Assembly has been formed by representatives of certain self-employed groups, for example, physicians, lawyers, dentists, accountants, pharmacists, realtors, farmers, and businessmen for the sole purpose of advocating the enactment by the Congress of H. R. 9 and H. R. 10, the Jenkins-Keogh Bills, and

WHEREAS, The American Thrift Assembly has the endorsement and support of the American Medical Association, American Bar Association, and national organizations of other self-employed persons, and

WHEREAS, Plans are being made for the formation of local and district committees in Ohio and in other states, to carry on the activities of the Thrift Assembly in support of the Jenkins-Keogh Bills which provide for an income tax deduction by self-employed persons of a certain percentage of premiums paid into retirement plans, and

WHEREAS, The Ohio State Medical Association on several occasions has endorsed proposals like the Jenkins-Keogh Bills,

THEREFORE BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association in session in Columbus, Ohio, May 14, 15, 16, reaffirms its endorsement and support of the Jenkins-Keogh Bills and urges all members of the Association to give their active support to Thrift Assembly committees which are being organized in Ohio to further the enactment of legislation of this character.

RESOLUTION C

Dr. Dooley stated that Resolution C concerning the Atomic Energy Act, introduced by Dr. Charles W. Pavey, Columbus, had been reviewed by his committee and that the committee had suggested certain minor amendments and the insertion of another "whereas" paragraph. **He moved the adoption of the committee's approval of Resolution C with amendments and the motion of approval was adopted. As amended and approved, Resolution C reads as follows:**

AMENDED RESOLUTION C

"WHEREAS, The states license physicians to use all drugs and agents useful in the diagnosis and treatment of disease; and

"WHEREAS, Radioactive isotopes have already been proved and are continuing to be proved by doctors of medicine of widely diverse interests to have extraordinarily wide and unique applications as clinical biochemical tools and drugs that are useful in the diagnosis or treatment of disease; and

"WHEREAS, The Atomic Energy Commission has, upon the advice of persons not all of whom are physicians, elected to regulate the possession and use in medicine of radioactive isotopes produced incidental to nuclear fission, by doctors of medicine already licensed by the states by requiring of them an additional and a redundant license for such possession and use of artificial radioactive isotopes in medicine; and

"WHEREAS, Doctors of Medicine licensed by the states are better qualified than are lay persons to decide what is in the best interests of their patients in respect to the possession for, and the use of, artificial radioactive isotopes in the practice of medicine; and

"WHEREAS, The House of Delegates of the AMA has stated, 'In any hospital, the use of radium or its products and artificially produced radioactive isotopes for diagnostic or therapeutic purposes shall be restricted to qualified physicians so judged by the Committee on Radium and Artificially Produced Radioactive isotopes of the professional staff to be adequately trained and competent in their particular use.'"

"WHEREAS, The present unnecessarily cumbersome and unnatural regulation of the possession and use of artificial radioactive isotopes in medicine by the Atomic Energy Commission hampers progress by removing incentives to teach and to learn what is already known to be good about peacetime uses of atomic energy in medicine, and it stifles initiative to discover new applications or to improve existing applications of radioactive isotopes in the diagnosis or treatment of disease; now, therefore

"BE IT RESOLVED, By the House of Delegates of the Ohio State Medical Association, that its delegates be instructed to introduce and to press for adoption by the House of Delegates of the American Medical Association for the rec-

ommendation by it to the Congress of the United States of the enactment of the meaning of the following proposed amendment to the Atomic Energy Act of 1954:

"The U. S. Atomic Energy Commission shall exempt doctors licensed to practice medicine in any state from any requirement for a license to transfer or receive in interstate commerce, manufacture, produce, transfer, acquire, own, possess, use or import any by-product material (radioactive isotopes) for medical purposes."

RESOLUTION U

Dr. Dooley reported that his committee had made minor changes in Resolution U, introduced by Dr. Asher Randell, Youngstown, and **recommends the adoption of a Substitute Resolution U, reading as follows:**

SUBSTITUTE RESOLUTION U

"WHEREAS, Some Blue Cross, Blue Shield and commercial insurance policies contain the following clauses, or similar provisions:

"Benefits are provided as specified below for diagnostic X-Ray examinations, either in or out of the hospital, which are required in the diagnosis of any condition of disease or injury and which are either:

"(a) Ordered by a licensed physician or a doctor of dental surgery who is engaged in general or special practice other than radiology, and when so ordered, are made by a licensed physician (excluding a doctor of dental surgery or the doctor ordering such X-Rays), who limits his practice to radiology.

"(b) Made by a licensed physician (excluding a doctor of dental surgery) qualified to undertake radiologic examinations within the confines of a single specialty, and,

"WHEREAS, The above is restrictive and monopolistic and not in accord with sound medical practice or ethics, and

"WHEREAS, The above interferes with free choice, enterprise policies, and principles of medical societies throughout America.

"THEREFORE BE IT RESOLVED, That the Ohio State Medical Association oppose the use of such clauses as restrictive and monopolistic, and

"BE IT FURTHER RESOLVED, That the Ohio State Medical Association recommend the following amendment to such clauses to be submitted to companies whose policies contain such clauses:

"Benefits are provided as specified below for diagnostic X-Ray examinations either in or out of the hospital which are required in the diagnosis of any condition of disease or injury."

On motion by Dr. Dooley, seconded and carried, the committee's recommendation that Sub. Resolution U be approved, was adopted.

RESOLUTION V

Dr. Dooley reported that the committee agreed with the intent of Resolution V, introduced by Dr. George A. Boon, Oak Harbor, which read as follows:

WHEREAS, We, the members of the Ottawa County Medical Society, have become acutely aware of the inroads toward socialism that are being made by the enemies of free enterprise and the advocates of central nationalization and the welfare state, and

WHEREAS, We do believe that our present form of free, private enterprise is responsible for our status in world leadership, not only in medicine but also the fields of economics, labor, management, freedom of speech, religious tolerance, and many others, and

WHEREAS, We observe that in other lands where these freedoms have succumbed to the Pollyanna promises of left-wing elements, government has deteriorated; self-confidence has been destroyed; self-respect has no rewards; and personal ambition has become old fashioned; and

WHEREAS, Our organization sincerely hopes and prays that no further freedom will be given up by default and our typical American naivete in conceding or giving up our rights gradually,

BE IT RESOLVED, That we manifestly proclaim our support of the American traditions of Constitutional government; of proper delegation of rights to the Sovereign States and local communities; of free and private enterprise; of



Past-Presidents were guests at The Council dinner held during the Annual Meeting. Above are three members of the Council shown with three Past-Presidents. L. to r., Dr. Charles L. Hudson, Dr. H. M. Platter, Retiring-President Richard L. Meiling, Dr. J. H. J. Upham, Incoming-President Robert S. Martin, and Dr. C. C. Sherburne.

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federal abstention from control of education, management, labor, religion, and the professions; and that we abhor and will oppose the evil influence of those visionaries and groups who would attempt to mislead us down the road of creeping socialism toward an unattainable Utopia but eventual disillusion.

The committee, however, suggested that some change in wording should be made. It drafted a Substitute Resolution V, reading as follows, and recommended its adoption:

SUBSTITUTE RESOLUTION V

"WHEREAS, The Ohio State Medical Association believes that our present form of free, private enterprise is responsible for our status in world leadership, not only in medicine but also the fields of economics, labor, management, freedom of speech, religious tolerance, and many others, and

"BE IT RESOLVED, That we manifestly proclaim our support of the American traditions of constitutional government; of proper delegation

of rights to the Sovereign States and local communities; of free and private enterprise; of federal abstention from control of education, management, labor, religion, and the professions."

On motion by Dr. Dooley, seconded and carried, the recommendation in favor of Substitute Resolution V was approved.

Dr. Dooley then moved that the report of his committee, as amended, be approved. **The motion was seconded and carried.** Dr. Dooley expressed appreciation to the members of his committee for their excellent work and for the time given to the committee's activities. Other members of the committee were: Robert S. Caulkins, Jr., Delaware County; Floyd M. Elliott, Hardin County; J. Robert Hudson, Hamilton County; H. C. Knierim, Richland County; Donald I. Minnig, Summit County; Benjamin S. Park, Lake County; R. G. Plummer, Licking County; Frank F. A. Rawling, Lucas County; George N. Spears, Lawrence County; Norman L. Wright, Coshocton County.

Dr. Meiling thanked Dr. Yantes and Dr. Dooley for their excellent reports and they and their committees were given an ovation by the House of Delegates.

ELECTION OF PRESIDENT-ELECT

The next order of business was the nomination and election of a president-elect.

Dr. Dale A. Hudson, Miami County, was recognized. He placed in nomination the name of Dr. George A. Woodhouse, Pleasant Hill, currently serving as Councilor of the Second District, for the office of president-elect. The motion was seconded by several delegates.

There being no further nominations, on motion by Dr. Gustafson, Youngstown, the nominations were closed and the secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Woodhouse for the office of president-elect. The president so ordered and the ballot was cast for Dr. Woodhouse.

Dr. Woodhouse was escorted to the podium and he made a brief talk to the House of Delegates, pledging his services and efforts to furthering the programs and activities of the Association. He emphasized particularly the need for strong local medical societies and action in all counties on matters of importance to the medical profession, including participation in civic and public affairs.

ELECTION OF COUNCILORS

The Committee on Nominations then reported, the report being presented by Dr. Harry K. Hines, Cincinnati, chairman of that committee.

The committee placed in nomination for members of The Council the following: Fourth District—Dr. Paul F. Orr, Perrysburg; Sixth District—Dr. Carl A. Gustafson, Youngstown; Eighth District—Dr. Wm. D. Monger, Lancaster; Tenth District—Dr. E. H. Artman, Chillicothe.

The nominations were closed and the secretary was instructed to cast the unanimous ballot of the House of Delegates for Doctors Orr, Gustafson, Monger and Artman. This was done and the president declared them elected for a term of two years— 1957-1958 and 1958-1959.

The committee placed in nomination the name of Dr. Frank H. Mayfield, Cincinnati, for the office of Councilor of the First District for a term of one year. Dr. Mayfield had been appointed to that office to fill a vacancy after the 1956 session of the House of Delegates. In accordance with Section 7, Chapter 8, of the By-Laws, the office must be filled by the House of Delegates for the balance of the term, namely, one year.

There being no further nominations, on motion duly made, seconded and carried, the nominations were closed and the secretary instructed to cast the unanimous ballot of the House of Delegates for Dr. Mayfield for the office of Councilor of the First District for the year 1957-1958. This was done and the president declared Dr. Mayfield elected.

The committee placed in nomination the name of Dr. George A. Woodhouse, Pleasant Hill, to succeed himself as Councilor of the Second District.

Dr. Meiling declared that Dr. Woodhouse would be inelegible for that office as he had been elected president-elect. He called for nominations from the floor. Dr. Kenneth D. Arn, Montgomery County, placed in nomination the name of Dr. R. Dean Dooley, Dayton, for the office of Councilor of the Second District, to serve a term of two years. **There being no further nominations, on motion duly made, seconded and carried, the nominations were closed and the secretary instructed to cast the unanimous ballot for Dr. R. Dean Dooley for the office of Councilor of the Second District. This was done and the president declared Dr. Dooley elected for a term of two years—1957-1958 and 1958-1959.**

AMA DELEGATES, ALTERNATES

Dr. Hines then reported that the Committee on Nominations had prepared a slate for the office of delegate and office of alternate-delegate to the American Medical Association. The terms of four delegates and four alternates will expire on December 31, 1957.

The committee placed in nomination the names of the following for delegates and alternates to the A. M. A. to serve a two-year term beginning January 1, 1958:

Dr. Paul A. Davis, Akron, delegate, and Dr. Edmond K. Yantes, Wilmington, alternate.

Dr. Carll S. Mundy, Toledo, delegate, and Dr. Paul F. Orr, Perrysburg, alternate.

Dr. L. Howard Schriver, Cincinnati, delegate, and Dr. Charles Sebastian, Cincinnati, alternate.

Dr. C. C. Sherburne, Columbus, delegate, and Dr. R. L. Meiling, Columbus, alternate.

There being no further nominations, on motion duly made, seconded and carried, the nomina-



Silver Award in the Teaching Field went to these joint exhibits, sponsored by Dr. John J. Cranley and Dr. Raymond J. Krause, of Cincinnati.

tions were closed and the secretary was instructed to cast the unanimous ballot for the foregoing for the office of delegate and the office of alternate to the American Medical Association for two-year terms starting January 1, 1958.

Before retiring Dr. Hines thanked the members of his committee for their cooperation and assistance. Members of the committee were: Harry K. Hines, Cincinnati, chairman; Kenneth D. Arn, Dayton; Floyd M. Elliott, Ada; Frank F. A. Rawling, Toledo; Harry A. Haller, Cleveland; Donald I. Minnig, Akron; Glenn C. Dowell, Carrollton; James A. L. Toland, Cambridge; John J. Schwab, Gallipolis; Ralph W. Holmes, Chillicothe; O. J. Nicholson, Norwalk.

President Meiling then called the newly elected officers, councilors and A. M. A. delegates and alternates to the rostrum and inducted them into office. He then turned the official gavel over to Dr. Martin.

Dr. Martin's first official act as president of the Association was to present Dr. Meiling with a past-president's button. Dr. Martin then addressed the House of Delegates briefly, pledging his active work on behalf of the entire profession of the state and requesting active support and cooperation from members of the House of Delegates and all members.

President Martin then appointed members to certain standing committees of the Association. These appointments, as follows, were confirmed by the House of Delegates:

Committee on Education—Dr. Robert H. Kotte, Cincinnati, appointed for a term of five years. Dr. John A. Prior, Columbus, a member of the committee, to serve as chairman for the ensuing year.

Judicial and Professional Relations Committee—Dr. Perry R. Ayers, Columbus, to serve as a member of the committee for the years 1957-1958 and 1958-1959, filling the unexpired term of Dr. R. Dean Dooley, Dayton. Dr. Daniel E. Early, Cincinnati, a member of the committee, to serve as chairman for the ensuing year.

Committee on Public Relations and Economics—Dr. J. Robert Hudson, Cincinnati, reappointed for a term of five years. Dr. Frederick P. Osgood, Toledo, a member of the committee, to serve as chairman for the ensuing year.

Committee on Scientific Work—Dr. Louis G. Herrmann, Cincinnati, reappointed for a term of five years. Dr. A. Carlton Ernstene, Cleveland, to serve as chairman for the ensuing year.

NEW BUSINESS

Under the order of new business Dr. Paul F. Orr, Perrysburg, presented a motion thanking the Columbus Academy of Medicine for its hospitality and commending all persons who had anything to do with the 1957 Annual Meeting, judged to be one of the most successful in the history of the Association. The motion was seconded and adopted unanimously.

There being no further business, the House of Delegates adjourned sine die.

Attest: CHARLES S. NELSON,
Executive Secretary.

Mutual of Omaha To Continue as Medicare Agent in Ohio

The Ohio State Medical Association has been advised by Maj. Gen. Paul I. Robinson, executive director of the Medicare Program, that the government has renewed its contract with Mutual of Omaha to administer the Medicare Program in Ohio during the ensuing fiscal year.

AMA Compiling Revised Current Health Insurance Data

Latest information on voluntary prepayment medical benefit plans is being compiled by the AMA Council on Medical Service. Both the 10th revision of "Voluntary Prepayment Medical Benefit Plans" and the supplementary "Charts and Graphs" will be available soon. The former summarizes information on the benefits, organizational structure, premiums, enrollment, etc., of more than 100 plans designed to provide assistance in financing health care. The latter pamphlet contains composite statistical data showing aggregate claims experiences, administrative costs and enrollment figures as well as comparisons with similar figures published by other sources. Single copies will be available to physicians and medical societies, without charge, from the Council.

HOUSE OF DELEGATES
ROLL CALL—1957 MEETING

County	Delegate	First Session	Second Session
	FIRST DISTRICT		
ADAMS	Richard L. Woodyard	Present	Present
BROWN	Charles H. Maly	.....	Present
BUTLER	Neil Millikin	.....	Present
	Walter A. Reese	Present	Present
CLERMONT	Carl A. Minning	.....	Present
CLINTON	E. K. Yantes	Present	Present
HAMILTON	Harry K. Hines	Present	Present
	R. B. Homan	Present	Present
	Robert E. Howard	Present	.....
	Charles W. Hoyt	Present	Present
	J. Robert Hudson	Present	Present
	Daniel V. Jones	Present	.....
	Roy L. Kile	.....	Present
	J. Harold Kotte	Present	.....
	R. D. Mansfield	.....	Present
	Howard Pfister	.....	Present
	Virgil A. Plessinger	Present	Present
	C. A. Sebastian	Present	Present
	W. L. Strohmenger	Present	Present
	Earl C. Van Horn	Present	Present
	Carl F. Vilter	.....	Present
HIGHLAND	J. Martin Byers	Present	Present
WARREN	O. L. Layman	Present	Present
	SECOND DISTRICT		
CHAMPAIGN	I. Miller	Present	Present
CLARK	Wm. H. Crays	Present	Present
	E. W. Schilke	Present	Present
DARKE	Maurice M. Kane	Present	Present
GREENE	P. D. Espey	Present	Present
MIAMI	Dale A. Hudson	Present	Present
MONTGOMERY	Herbert R. Cammerer	Present	Present
	R. Dean Dooley	Present	Present
	T. L. Light	Present	Present
	Kenneth D. Arn	Present	Present
	Lynne E. Baker	Present	Present
PREBLE	C. J. Brian	Present	Present
SHELBY	G. J. Schroer	Present	Present
	THIRD DISTRICT		
ALLEN	Margaret E. Belt	.....	Present
	Fred P. Berlin	Present	Present
AUGLAIZE	Elizabeth Y. Kuffner	Present	Present
CRAWFORD			
HANCOCK			
HARDIN	F. M. Elliott	Present	Present
LOGAN	Hobart L. Mikesell	Present	Present
MARION	Daniel M. Murphy	.....	Present
MERCER			
SENECA	H. L. Abbott	.....	Present
VAN WERT	Edwin Wm. Burnes	Present	Present
WYANDOT	Allen F. Murphy	Present	Present
	FOURTH DISTRICT		
DEFIANCE	W. S. Busteed	Present	Present
FULTON	Richard K. Vogel	Present	
HENRY	Thomas F. Tabler	Present	Present
LUCAS	Henry A. Burstein	.....	Present
	Henry D. Cook	Present	.....
	J. Lester Kobacker	Present	Present
	Adelbert J. Kuehn	Present	.....
	Edward F. Ockuly	Present	Present
	Frank F. A. Rawling	Present	Present
	Howard E. Smith	Present	Present
	R. P. Whitehead	.....	Present
OTTAWA	Geo. A. Boon	Present	Present
PAULDING	D. E. Farling	.....	Present
PUTNAM			
SANDUSKY			
WILLIAMS	Paul G. Meckstroth	.....	Present
WOOD	R. A. Peatee	Present	Present
	FIFTH DISTRICT		
ASHTABULA	S. A. Burroughs	.....	Present
CUYAHOGA	James O. Barr	.....	Present
	J. L. Bilton	.....	Present
	F. L. Browning	Present	Present
	John H. Budd	.....	Present
	C. A. Colombi	Present	Present
	Eduard Eichner	Present	Present
	E. A. Ferreri	Present	Present
	J. J. Grady	Present	Present
	H. A. Haller	Present	Present
	John B. Hazard	Present	Present
	H. D. Iler	Present	Present
	C. R. Jablonoski	.....	Present
	Albert L. Jones	Present	Present
	F. R. Kelly	Present	Present
	John A. Kenney, Jr.	Present	Present
	Thomas D. Kinney	Present	.....
	M. H. Lambright, Jr.	Present	.....
	A. Macon Leigh	Present	.....
	Paul A. Mielcarek	Present	Present
	Frank Rack	.....	Present
	P. J. Robechek	Present	Present
	J. M. Rossen	Present	.....
	B. B. Sankey	Present	.....
	Paul J. Schildt	.....	Present
	Edwin L. Smith	Present	Present
	Leo H. Simonson	.....	Present
GEAUGA	Dale J. Hawk	Present	.....
LAKE	Benjamin S. Park	Present	Present
	SIXTH DISTRICT		
COLUMBIANA	John A. Fraser	Present	Present
MAHONING	Paul J. Mahar	Present	Present
	Asher Randell	Present	Present
	Fred G. Schlecht	Present	.....
PORTAGE	Arthur L. Knight	Present	.....
	Myron W. Thomas	.....	Present
STARK	Ralph L. Rutledge	Present	Present
	J. R. Seesholtz	Present	Present
	R. E. Tschantz	Present	.....
SUMMIT	P. B. deMaine	Present	Present
	Donald I. Minnig	Present	Present
	Harold E. Muller	Present	Present
	H. O. Musser	Present	Present
	Carl C. Nohe	Present	Present
TRUMBULL	E. R. Westbrook	Present	Present
	SEVENTH DISTRICT		
BELMONT	B. C. Diefenbach	Present	Present
CARROLL	Glenn C. Dowell	Present	Present
COSHOCTON	Norman L. Wright	Present	Present
HARRISON	George E. Henderson	Present	.....
JEFFERSON	Carl F. Goll	Present	Present
MONROE			
TUSCARAWAS	J. W. Hamilton	Present	Present
	EIGHTH DISTRICT		
ATHENS			
FAIRFIELD	J. L. Kraker	.....	Present
	Chester P. Swett	Present	.....
GUERNSEY	James A. L. Toland	Present	Present
LICKING	R. G. Plummer	Present	Present
MORGAN	Henry Bachman	Present	.....
MUSKINGUM	A. C. Ormond	Present	Present
NOBLE			
PERRY	Charles E. Bope	.....	Present
WASHINGTON	K. E. Bennett	.....	Present
	Ford E. Eddy	Present	.....
	NINTH DISTRICT		
GALLIA	John J. Schwab	Present	Present
HOCKING	C. T. Grattidge	.....	Present
JACKSON	C. C. Fitzpatrick	.....	Present
LAWRENCE	George N. Spears	Present	Present
MEIGS	Roger P. Daniels	Present	Present
PIKE	Paul H. Jones	.....	Present
SCIOTO	Oral D. Tatje	Present	Present
VINTON	H. D. Chamberlain	Present	Present
	TENTH DISTRICT		
DELAWARE	Robert S. Caulkins, Jr.	.....	Present
FAYETTE	James E. Rose	Present	.....
FRANKLIN	Drew J. Arnold	Present	Present
	Perry R. Ayers	Present	.....
	Mel A. Davis	Present	Present
	Robert M. Inglis	.....	Present
	Charles W. Matthews	Present	Present
	Jack W. Miles	Present	.....
	Charles W. Pavey	Present	Present
	Judson D. Wilson	Present	Present
	Wm. P. Smith, Jr.	.....	Present
KNOX	Henry T. Lapp	Present	Present
MADISON	Sol Maggied	Present	Present
MORROW	Joseph P. Ingmire	Present	Present
PICKAWAY	Francis W. Anderson	Present	Present
ROSS	Ralph W. Holmes	Present	.....
	Robert E. Swank	.....	Present
UNION	E. J. Marsh	Present	Present
	ELEVENTH DISTRICT		
ASHLAND	M. D. Shilling	Present	Present
ERIE	E. J. Meckstroth	Present	Present
HOLMES			
HURON	O. J. Nicholson	Present	Present
LORAIN	Ben V. Myers	Present	Present
	G. R. Wiseman	.....	Present
MEDINA	Nevin J. M. Klotz	Present	Present
RICHLAND	H. G. Knierim	Present	Present
	P. O. Staker	.....	Present
WAYNE			

(Continued on Next Page)

		First Session	Second Session
OFFICERS			
President	Richard L. Meiling	Present	Present
President-Elect	Robert S. Martin	Present	Present
Past-President	Charles L. Hudson	Present	Present
Treasurer	Geo. J. Hamwi	Present	Present
COUNCILORS			
District			
First	Frank H. Mayfield	Present	Present
Second	G. A. Woodhouse	Present	Present
Third	James R. Jarvis	Present	Present
Fourth	Paul F. Orr	Present	Present
Fifth	George W. Petznick	Present	Present
Sixth	C. A. Gustafson	Present	Present
Seventh	Robert E. Hopkins	Present	Present
Eighth	William D. Monger	Present	Present
Ninth	C. L. Pitcher	Present	Present
Tenth	Edwin H. Artman	Present	Present
Eleventh	H. T. Pease	Present	Present
	Totals	131	145

Dr. Cummer Honored by American Academy of Dermatology

At the last meeting of the American Academy of Dermatology and Syphilology, the Board of Directors of the Academy officially expressed apreciation to Dr. Clyde L. Cummer, Cleveland, for his many years of service as Director of Technical Exhibits for the sessions of the Academy. In recognition of this, the Board decreed that the Gold Award in Class II of the Scientific Exhibits will henceforth he known as the Clyde L. Cummer Gold Award. Dr. Cummer is a former president of the Ohio State Medical Association and for many years served as chairman of the Committee on Education of the OSMA. Under his chairmanship the Association established a widespread program of postgraduate lectures. These were abandoned during World War II and were not revived at the close of the war due to the fact that so many local and district societies have inaugurated local or regional courses of that type.

Doctors as Diplomats To Be Shown in New TV Film

American doctors around the world will be the theme of a full-hour color "March of Medicine" television film to be presented this fall by Smith, Kline & French Laboratories with the cooperation of the American Medical Association. The program will be built around the activities of American doctors throughout the world who, in their devotion to their profession, are good-will ambassadors for the United States. Private, missionary, military, foundation and government doctors will be featured. The production crew will journey to a number of far-flung locations, including Japan, Korea, Hong-Kong, Nepal, India, Sarawak, Indonesia, Iran, Turkey, Ethiopia, France and Guatemala. This "March of Medicine" program will be beamed over the NBC television network Tuesday, December 3, from 9:30 to 10:30 p. m., EST, during AMA's Clinical Session in Philadelphia.

Psychiatric-Neurologic Fees In VA Schedule Revised

At the request of the Ohio State Medical Association, the Veterans Administration has amended the Medical Fee Schedule applying to the Ohio Home Town Medical Care Program for disabled veterans to provide the following fees for psychiatric and neurology services, effective July 1, 1957:

0039	Examination by Psychiatrist to determine diagnosis	$15.00
0040	Examination by Neurologist to determine diagnosis	$15.00
0053	Psychiatric treatment, one-half hour or less	$ 7.50
0053A	Psychiatric treatment, period longer than one-half hour	$15.00
0054*	Neurologic treatment	$10.00

***If neurologic treatment consists essentially of the use of physical therapy, services will be authorized in accordance with the fee schedule for physiotherapy.**

****Delete 0054A (Major portion of each additional half-hour of neurologic treatment).**

New Mental Health Films Available from AMA

Three documentary mental health films recently have been added to the AMA Film Library. (1) "We, The Mentally Ill"—patients at St. Elizabeth's Hospital, Washington, D. C., present drama about mental illness based on the life of Dorothea Lynde Dix, mental health crusader; summarizes existing conditions in mental institutions and dramatic new medicines revolutionizing treatment. (2) "Alcoholism: The Revolving Door"—demonstrates early treatment of acute alcoholism with both psychotherapy and new drug therapy; covers meeting of Alcoholics Anonymous; dramatizes conditions on Skid Row. (3) "Man in Shadow"—dramatic presentation of man's struggle to overcome mental illness, expertly combined with documentary film taken at Cleveland State Hospital where patients are seen at their daily routines; presents one patient's reactions to various forms of treatment. First two are 16mm, black-and-white, 30-minute, sound films from the "March of Medicine" television series. Last film is 16mm, black-and-white, 52 minutes, sound, originally shown on "Armstrong Circle Theater" television program.

Annual Meeting Attendance . . .

More Than 1600 Physicians and Medical Students Attend 1957 Meeting In Columbus; Roster Shows How Membership Turned Out by Counties

THE total attendance at the 1957 Annual Meeting, Ohio State Medical Association in Columbus, May 14-16, was 2,690 including members of the Association; interns, residents and other physician guests; medical students and others who were present. The actual break-down was as follows: Members of OSMA, 1,164; interns, residents and other physician guests, 149; medical students, 320; members of the Woman's Auxiliary, nurses and other medical aides, and miscellaneous guests, 689; scientific and technical exhibitors, 368; total, 2,690.

Following are registration figures for members by counties, a comparison of attendance figures at Annual Meetings from 1919 to 1957, followed by a roster of members who registered for the 1957 meeting:

REGISTRATION, 1957 ANNUAL MEETING BY COUNTIES, AND MEMBERSHIP DATA

County	Total Membership Dec. 31, '56	Total Membership May 10, '57	Annual Meeting Registration
Adams	10	11	2
Allen	110	108	13
Ashland	25	24	6
Ashtabula	61	59	3
Athens	37	34	6
Auglaize	20	18	3
Belmont	51	54	9
Brown	13	13	1
Butler	148	154	9
Carroll	9	8	1
Champaign	18	17	5
Clark	116	110	16
Clermont	27	24	2
Clinton	27	25	8
Columbiana	76	59	8
Coshocton	20	21	6
Crawford	35	32	11
Cuyahoga	2058	1923	108
Darke	21	24	6
Defiance	17	18	2
Delaware	23	25	9
Erie	55	59	7
Fairfield	49	49	14
Fayette	16	16	5
Franklin	801	754	334
Fulton	24	23	2
Gallia	34	30	4
Geauga	10	12	2
Greene	39	41	7
Guernsey	35	34	6
Hamilton	1161	1101	79
Hancock	41	41	5
Hardin	28	24	3
Harrison	11	10	1
Henry	13	13	2
Highland	23	22	10
Hocking	11	11	5
Holmes	9	9	0
Huron	23	23	4
Jackson	16	16	7
Jefferson	52	53	2
Knox	33	32	10
Lake	56	57	3
Lawrence	26	26	8
Licking	61	61	19
Logan	26	24	7
Lorain	153	150	7
Lucas	536	519	33
Madison	11	11	3
Mahoning	273	281	21
Marion	59	58	12
Medina	36	34	4
Meigs	9	9	1
Mercer	19	19	2
Miami	57	57	13
Monroe	4	3	0
Montgomery	462	448	63
Morgan	5	4	3
Morrow	9	8	4
Muskingum	64	63	11
Noble	3	3	1
Ottawa	17	19	2
Paulding	9	10	1
Perry	12	12	4
Pickaway	15	17	3
Pike	10	9	5
Portage	38	42	8
Preble	11	11	1
Putnam	13	14	2
Richland	109	107	24
Ross	49	49	19
Sandusky	48	40	2
Scioto	76	74	13
Seneca	40	37	3
Shelby	19	17	5
Stark	303	304	24
Summit	421	431	26
Trumbull	119	120	11
Tuscarawas	58	55	15
Union	20	20	6
Van Wert	16	15	5
Vinton	4	2	1
Warren	17	17	4
Washington	28	23	4
Wayne	58	58	4
Williams	16	16	3
Wood	40	36	5
Wyandot	14	13	6
Totals	8858	8557	1164

ANNUAL MEETING REGISTRATION FOR 1919-1957 INCLUSIVE

Year	Place	Members	Guest Physicians	Medical Students	Woman's Aux.; Misc. Guests	Sc. and Tech. Exhibitors	Total
1919	Columbus	1173			264	92	1539
1920	Toledo	860			105	80	1062
1921	Columbus	1275			104	96	1503
1922	Cincinnati	1066			184	70	1341
1923	Dayton	1117			202	76	1414
1924	Cleveland	1301			180	109	1603
1925	Columbus	1204			361	107	1689
1926	Toledo	903			120	83	1125
1927	Columbus	1320			286	82	1705
1928	Cincinnati	916			92	80	1115
1929	Cleveland	1231			249	124	1619
1930	Columbus	1241			435	86	1775
1931	Toledo	826			198	50	1087
1932	Dayton	978			201	45	1226
1933	Akron	858			160	25	1049
1934	Columbus	1069			410	51	1539
1935	Cincinnati	973			197	84	1271
1936	Cleveland	1099			563	137	1813
1937	Dayton	1103			366	64	1551
1938	Columbus	1330			619	104	2068
1939	Toledo	1056			271	84	1426
1940	Cincinnati	1126			323	114	1589
1941	Cleveland—Joint Meeting with A. M. A.						
1942	Columbus	1221			527	119	1880
1943	Columbus	544			160		717
1944	Columbus	830			441	130	1421
1945	No Meeting						
1946	Columbus	1262	130	65	507	157	2121
1947	Cleveland	1502	158	15	411	328	2414
1948	Cincinnati	1362	293	27	491	214	2387
1949	Columbus	1533	162	221	462	230	2608
1950	Cleveland	1587	260	102	707	376	3032
1951	Cincinnati	1208	162	185	647	352	2554
1952	Cleveland	1366	204	49	687	395	2701
1953	Cincinnati	1155	180	224	578	298	2435
1954	Columbus	1222	197	173	701	252	2545
1955	Cincinnati	1360	211	184	738	317	2810
1956	Cleveland	1601	338	120	1029	489	3577
1957	Columbus	1164	149	320	689	368	2690

MEMBERS OF STATE ASSOCIATION REGISTERED AT 1957 MEETING

Adams County—Hazel L. Sproull, Richard L. Woodyard.

Allen County—Margaret E. Belt, Fred P. Berlin, Thomas L. Edwards, Bernard Glass, John A. Glorioso, John D. Hubbell, Charles H. Leech, Walter A. Noble, Melville D. Soash, David L. Steiner, Roger L. Tecklenberg, Russell L. Wiessinger, Carl H. Zinsmeister.

Ashland County—George M. Emery, Paul E. Kellogg, Charles H. McMullen, Glenn Paisley, Myrle D. Shilling, Wayne C. Smith.

Ashtabula County—Walter J. Brown, Shepard A. Burroughs, Harry K. Lynne.

Athens County—Wolfhard Baumgartel, Arthur L. Dobosiewicz, Roary A. Murchison, Tamin J. Najm, Clarence N. Sanders, Stephen E. Simay.

Auglaize County—Elizabeth Y. Kuffner, James R. Romaker, Theodore H. Will.

Belmont County—Angelo J. Antalis, Edward V. Arbaugh, Jr., David Danenberg, Benjamin C. Diefenbach, Harry G. Harris, Murray B. Hunter, Peter Lancione, Lewis L. Liggett, Harvey H. Murphy.

Brown County—Charles H. Maly.

Butler County—H. Thomas Atkins, Clyde G. Chamberlin, Jack L. Harris, William H. Henry, Joseph R. Hufschmitt, James L. Kingsland, Neil Millikin, Walter A. Reese, Robert M. Wilson.

Carroll County—Glenn C. Dowell.

Champaign County—V. R. Frederick, Joseph Friedberger, Forrest E. Lowry, Isador Miller, Arthur B. Ream.

Clark County—Martin J. Cook, William H. Crays, William J. Habeeb, G. E. Heinrich, George R. Horton, Wesley E. Knaup, John D. LeFevre, Morris B. Martin, Robert A. McLemore, Louis H. Mendelson, William H. Miller, William B. Quinn, Carl H. Reuter, Edward L. Ringer, Geneva L. Shong Rothemund, E. W. Schilke.

Clermont County—Carl A. Minning, F. S. Skeen.

Clinton County—Robert Conard, J. H. Frame, Kelley Hale, V. E. Hutchens, Arthur F. Lippert, Frank G. Plymire, William L. Wead, Edmond K. Yantes.

Columbiana County—Harlow F. Banfield, Jr., William S. Banfield, R. C. Costello, John A. Fraser, Virgil C. Hart, Raymond T. Holzbach, William J. Horger, Janis Lauva.

Coshocton County—Floyd W. Craig, Gerald A. Foster, Robert E. Hopkins, Howard H. Schwindt, James G. Smailes, Norman L. Wright.

Crawford County—Clarence Adams, Jack W. Arnold, Darrel D. Bibler, Gerald E. Blanchard, Arnold Eicens, Martin M. Horowitz, Gotholds Kalnins, John M. Kidd, Bernard M. Mansfield, Theodore D. Sawyer, Robert L. Solt.

Cuyahoga County—William E. Abbott, Paul H. Bade, Elmer J. Ballintine, James O. Barr, John D. Battle, Jr., Joseph L. Bilton, Leonard H. Biskind, Francis L. Browning, John H. Budd, Thomas E. Burney, Hilda B. Case, David A. Chambers, Austin B. Chinn, Kenneth W. Clement, Christopher A. Colombi, William H. Cope, Russell B. Crawford, Paul C. Crone, Hamilton S. Davis, Nicholas G. DePiero, Stanley N. P. DeVille, Victor G. DeWolfe, Fred W. Dixon, Daniel V. Dougherty, Carroll C. Dundon, Donald B. Effler, Eduard Eichner, A. Carlton Ernstene, F. Graham Fallon, Eugene A. Ferreri,

Farrell T. Gallagher, W. James Gardner, John J. Grady, Donald E. Hale, Harry A. Haller, Harold E. Harris, John W. Harris, John R. Haserick, Robert B. Hauver, John B. Hazard, Charles C. Higgins, Robert A. Hingson, Stanley O. Hoerr, Charles L. Hudson, Alfred W. Humphries, William W. Huntress, H. D. Iler, C. R. Jablonoski, Albert L. Jones, Sidney Katz, Walter R. Katzenmeyer, Earle B. Kay, Oliver J. Kechele, Fred R. Kelly, Roscoe J. Kennedy, John A. Kenney, Jr., Dominika Kesiunaite, Thomas D. Kinney, Edward M. Kline, Michael J. Krisko,

John H. Lazzari, Charles L. Leedham, A. Macon Leigh, Walter O. Lewin, Thomas N. MacKrell, Robert D. Mercer, Paul A. Mielcarek, Nicholas Misischia, Paul A. Nelson, William E. Neville, William A. Nosik, Frank E. Nulsen, Peter P. Palsis, Myron M. Perlich, George W. Petznick, J. K. Potter, Frank J. Rack, Frederick E. Roach, Philip J. Robechek, Daniel P. Roberto, Marvin Rollins, Joseph McK. Rossen, Harold P. Roth, Morton A. Roth, Edward C. Roy,

Brant B. Sankey, Morton Sass, Arthur L. Scherbel, Paul J. Schildt, Roger B. Scott, Keith W. Sheldon, Leo H. Simoson, Penn G. Skillern, James E. Slivka, Edwin L. Smith, Joseph A. Solomayer, F. Mason Sones, Jr., John Storer, Shelley M. Strain, Harold R. Swan, Richard L. Taylor, Rupert B. Turnbull, Jr., Charles E. Van Mason, Howard S. Van Ordstrand, H. C. Weinberg, Harold C. Wise, George W. Wright, James N. Wychgel.

Darke County—Emmett W. Arnold, Edward Westbrook Browne, Maurice M. Kane, John S. Meyers, Peter H. Mulder, Daryle M. Parker.

Defiance County—William S. Busteed, Jack A. Kane.

Delaware County—Henry Bergman, Adelbert R. Callander, Robert S. Caulkins, Jr., Donald L. Gantt, Mary K. Kuhn, Irene L. Lazdins, Francis W. Logan, Robert A. Vogel, William L. Vogt.

Erie County—William F. Burger, William T. Fenker, James R. Hart, Seldon R. Hoover, David R. Lehrer, Emil J. Meckstroth, H. L. Sowash.

Fairfield County—Charles F. Clark, Joseph A. Geer, William S. Jasper, George F. Jones, A. M. Kelley, Victor N. Kistler, Jack L. Kraker, George W. LeSar, Carl R. Reed, Edward B. Roller, Harold J. Schwendeman, Chester P. Swett, Kenneth W. Taylor, Robert E. Whetstone,

Fayette County—Joseph M. Herbert, Jack H. Persinger, James E. Rose, Marvin H. Roszmann, Byers W. Shaw.

Franklin County—Kenneth H. Abbott, B. W. Abramson, L. Adelman, Tibor Agoston, Louise P. Ainsworth, Marion L. Ainsworth, Donald J. Alspaugh, James M. Andrew, Shirley Armstrong, Drew J. Arnold, William F. Ashe, Ralph F. Askam, Jr., Robert J. Atwell, Perry R. Ayres, Calvin L. Baker, Lloyd W. Barnes, Morris L. Battles, Walter Baum, Harry C. A. Beach, Hugh G. Beatty, William R. Beery, C. H. Benson, Hugo A. Berzins, Irvin Black, John H. Blackburn, Rozier E. Bland, J. M. B. Bloodworth, Jr.

Walter C. Boenheim, Robert W. Bohl, E. Thomas Boles, Jr., John P. Bolton, George H. Bonnell, Jr., R. W. Bonnell, Joseph A. Bonta, Jack R. Bontley, Bertha A. Bouroncle, John G. Boutselis, Charles F. Bowen, Wade D. Bower, Joseph R. Boyle, William F. Bradley, Paul E. Brady, Richard I. Brashear, Harley O. Bratton,

Gill W. Brehm, Wayne Brehm, Bernard J. Brief, John Earl Briggs, Grace Nunemaker Brown, Harold E. Brown, John E. Brown, Jr., John Q. Brown, Robert H. Browning, William H. Brunie, Roderick A. Bryce, Sylvia Bubis, Maurice G. Buckles, Daniel S. Bunner, William E. Burkhart, Jonathan G. Busby, Alice M. Bustin,

Benjamin B. Caplan, William H. Carter, Lewis W. Cellio, Leon G. Claassen, Samuel G. Clark, Thomas E. Clark, H. William Clatworthy, Jr., George D. Clouse, Kenneth A. Clouse, Oscar L. Coddington, Arthur R. Cohen, George F. Collins, George Cooperrider, William E. Copeland, Dorence S. Cowles, Dana W. Cox, William L. Craver, John P. Crawford, William E. Crisp, Stuart P. Cromer, Robert F. Daly, Drew L. Davies, Francis W. Davis, Mel A. Davis, William W. Davis, Charles J. Deishley, Walter De la Motte, C. J. Delor, Dale R. Dickens, Frederick W. Dierker, J. M. Dunn,

Ray E. Ebert, F. J. Ebstein, Samuel D. Edelman, Jesse Eisen, Nathan P. Eisenberg, Edwin H. Ellison, Elmer D. Engelman, Herbert K. Ervin, Frederick C. Finke, Jerome Fisher, Rivington Fisher, T. R. Fletcher, Frederick A. Flory, Jonathan Forman, Wiley L. Forman, Joseph C. Forrester, Frank C. Frailie, Robert L. Friedman, Huston F. Fulton, John S. Fung, Wesley Furste, Clarence M. Gallagher, Frank T. Gallen, John P. Garvin, John Gersten, Joseph M. Gettrost, Howard D. Giles, Robert F. Goldberg, James C. Good, Milton L. Goodman, Emilie C. Gorrell, Mary Ann Graber, Grant O. Graves, Helen Pierson Graves, John B. Gravis, Leonard B. Greentree, William R. Griffin, Elmer M. Groff,

Morton Hajos, Fred E. Hall, William L. Hall, William Hamelberg, Walter H. Hamilton, Geo. J. Hamwi, Forest C. Haney, Glenn J. Haninger, Dorence O. Hankinson, James A. Hardie, Charles W. Harding, Frances K. Harding, George T. Harding, III, Philip B. Hardymon, Harold K. Harris, Margot D. Hartmann, Paul M. Hatfield, William H. Havener, Ruth C. Haynes, Walter M. Haynes, Jr., Robert A. Heilman, Richard B. Heintz, Gabriel C. Heller, Frank H. Herrington, David K. Heydinger, Warren W. Hicks, Willis H. Hodges, George R. Hoeflinger, Julius Hoffman, Walter A. Holbrook, Zeph J. R. Hollenbeck, John H. Holzaepfel, M. D., Reuben B. Hoover, Don M. Hosier, O. W. Hosterman, William H. R. Howard, Franklin C. Hugenberger, Harold I. Humphrey, William E. Hunt, Brooks H. Hurd, William G. Hutchison,

Robert J. Izant, Jr., Jay Jacoby, Arthur G. James, Raymond L. Jennings, Oscar W. Jepsen, Ralph J. Johansmann, Charles E. Johnston, Max P. Kanter, Henry W. Karrer, Chester T. Kasmersky, Robert A. Keating, Robert A. Kidd, Jr., C. C. Kirk, Gilman D. Kirk, Robert C. Kirk, Ben R. Kirkendall, Calvin B. Kitchen, K. P. Klassen, Earl P. Knisely, Joseph Kosar, Albert Kostoff, George O. Kress, Robert H. Kuhn, Frank J. Lacksen, Frank L. Lally, Cornelius C. Landen, Albert B. Landrum, Hedwig D. Lang, Carlos M. Larrick, Robert B. Larrick, Edward C. Lawless, Harry E. Lefever, Warren H. Leimbach, Norris E. Lenahan, Heinrich J. Leuchter, David R. Lewis, Tom F. Lewis, James W. Long, Otto J. Lowy,

Joseph Macys, Robert H. Magnuson, Torrence A. Makley, James R. Manchester, Lillian Marks, C. R. Markwood, Anthony R. Marsicano, George T. Mathews, Charles W. Matthews, Earl D. McCallister, Richard L. McFarland, Charles W. McGavran, Charles W. McGavran, II, John W. Means, Charles V. Meckstroth, Richard L. Meiling, H. Ben Merkle, Paul D. Meyer, William G. Meyer, Nicholas Michael, Jack W. Miles, Howard R. Mitchell, William Molnar, James R. Monroe, William R. Morse, Jacob Moses, E. V. Mosley, Link M. Murphy, William G. Myers,

Sidney W. Nelson, Harry O. Newland, William A. Newton, Jr., James W. Norris, Walter E. Obetz, Anton W. Oelgoetz, Munroe W. Palestrant, Milton M. Parker, Carey B. Paul, Jr., Charles W. Pavey, Claude S. Perry, Robert E. Pickett, Irving Pine, H. M. Platter, Pliny A. Price, Leonards Primanis, I. Darin Puppel, Dale E. Putnam, Philip J. Reel, John H. Richardson, Frank A. Riebel, William O. Robertson, Jr., Julian H. Robinson, Samuel W. Robinson, A. Sophie Rogers, Philip C. Rond, Jr., Fred I. Rose, John H. Rosemond, Jr., Carl W. Roth, Louis J. Roth, Norman O. Rothermich, Henry A. Rowe, Anthony Ruppersberg, Jr., Earl H. Ryan, Charles J. Ryan, Joseph M. Ryan,

Samuel Saslaw, William H. Saunders, Martin Peter Sayers, Gerald G. Schreiber, Edward R. Schumacher, Henry H. Schwarzell, Wendell P. Scott, Harry E. Secrest, Roy J. Secrest, Lester Seligson, Miner W. Seymour, Thomas E. Shaffer, Clifford C. Sherburne, Abram J. Shoemaker, Wilson P. Shortridge, George P. Sims, Robert E. Sinclair, Howard D. Sirak, Clayton S. Smith, William P. Smith, Jr., Constantine H. Solomonides, Robert R. Sommer, Juliet Stanton, John E. Stephens, Mabel Richards Tarbell, Jack N. Taylor, Jack E. Tetirick, Harry W. Topolosky, Lawrence E. Turton,

John C. Ullery, Friedrich Karl Urschler, A. W. Verhoff, E. von Haam, Watson H. Walker, Albert B. Walton, Thomas P. Wangler, Harold W. Ward, James H. Warren, Richard H. Wehr, Damon E. Wetterauer, Warren E. Wheeler, John D. White, Joseph P. Whitlatch, James H. Williams, Thomas J. Williams, Benjamin F. Wills, Eugene I. Wilson, Henry E. Wilson, Judson D. Wilson, Charlotte Winnemore, Bruce K. Wiseman, Ralph E. Worden, Henry J. Wynsen, Robert E. S. Young, Edwin R. Zartman, Carolyn H. Ziegler, John B. Ziegler, Richard W. Zollinger, Maurice L. Zox.

Fulton County—Robert A. Ebersole, Richard K. Vogel.

Gallia County—W. Lewis Brown, Norvil A. Martin, Thomas W. Morgan, John J. Schwab.

Geauga County—Dale J. Hawk, Shigeki Hayashi.

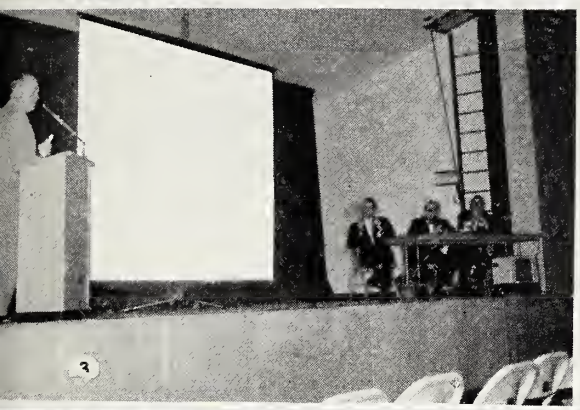
Greene County—Ray W. Barry, Harry M. Berley, Paul D. Espey, Robert D. Hendrickson, Carl D. Hyde, Clarence G. McPherson, John D. Tharp.

Guernsey County—William W. Bryant, Thomas W. Frame, Jesse B. Kellum, Victoria Miknis, Robert A. Ringer, James A. L. Toland.

Hamilton County—Myrta M. Adams, Charles B. Armstrong, Charles M. Barrett, Erwin C. Binstadt, Norman H. Blatt, Lester J. Bossert, Byron E. Boyer, Edward F. Buyniski, Ralph G. Carothers, Edgar M. Corrill, William H. Craddock, John J. Cranley, Jr., Joseph G. Crotty, William R. Culbertson, John E. Finke, Paul E. Foldes, Edward A. Gall, N. J. Giannestras, Jerome Giuseffi, Jr., Edward A. Grad, Marjorie A. Grad, Douglas P. Graf, Albert L. Haas, John W. Hauser, J. Robert Hawkins, Edward B. Headley, James A. Helmsworth, Louis G. Herrmann, Elliott A. Hilsinger, Harry K. Hines, Richard B. Homan, Robert E. Howard, Charles W. Hoyt, J. Robert Hudson,

Dennis E. Jackson, Joseph H. Jansen, Jr., William R. Johnson, Jr., Daniel V. Jones, Roy L. Kile, Harvey C. Knowles, Jr., Homer H. Kohler, Herman J. Kooiker, J. Harold Kotte, Raymond J. Krause, Robert E. Krone, J. Arthur Leary, Edgar S. Lotspeich, Jr., Robert D. Mansfield, Mary M. Martin, Frank H. Mayfield, Robert L. McLaurin, Henrietta Marie Miller, Carl J. Ochs,











General Session Panels Draw Large Attendance

1. Dr. M. J. Nicholson, Boston, one of the guest speakers.

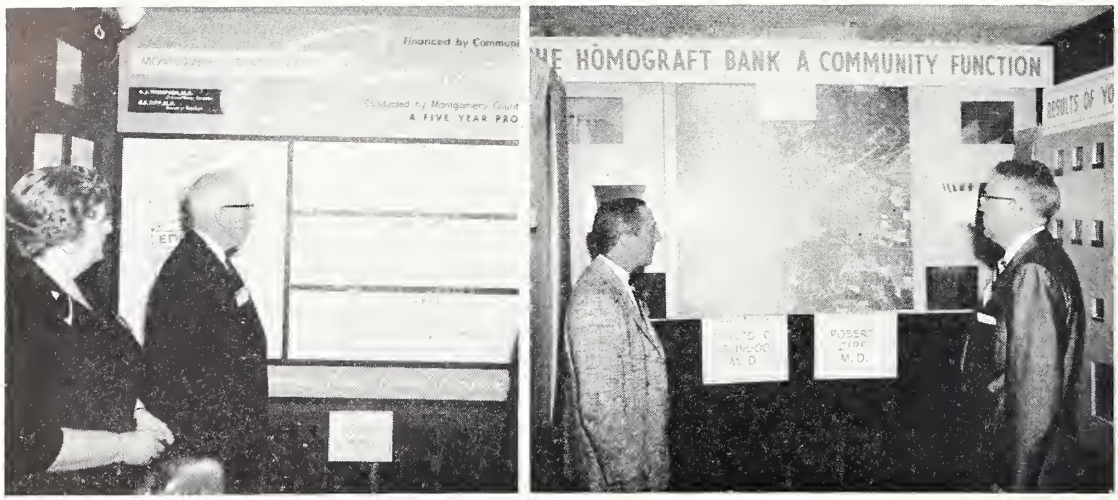
2. A typical scene in the Assembly Hall during a General Session.

3. Dr. Mayfield, left, moderates panel on automobile accidents. The panel, left to right, are John O. Moore, Dr. G. J. Curry and Dr. A. P. Aiken, all guest speakers.

4. The panel on the "Medical Witness," l. to r., Dr. LeFever, Dr. Wilson, Mr. Alloway and Mr. Stichter. Moderator was Mr. Stetler, of the AMA Law Office.

5. The panel on "The Doctor and the Law," l. to r., Mr. Stetler, Mr. Stichter and Mr. Morris.

6. At the House of Delegates session, Dr. Meiling relinquishes the gavel to Incoming-President Martin.



A special award for outstanding exhibits was given to these displays by the Montgomery County Medical Society. The titles are: "Montgomery County Society for Cancer Control," and "The Homograft Bank—A Community Function."

Charles L. Pfeiffer, Howard F. C. Pfister, Virgil A. Plessinger, Andrew C. Renz,

Frank J. Scharold, L. Howard Schriver, A. L. Schwartz, Charles A. Sebastian, Denman Shaw, Robert M. Sherman, Dora F. Sonnenday, Mervin F. Steves, Warren L. Strohmenger, Garfield L. Suder, William S. Terwilleger, William C. Thornell, Earl C. Van Horn, Carl F. Vilter, Richard W. Vilter, Luben S. Walchef, Calvin F. Warner, Henry E. Wedig, C. Merle Welch, George A. Woodhouse, Jr., Charles E. Work, M. M. Zinninger.

Hancock County—William E. Brown, Harold O. Crosby, R. Grant Janes, Ralph E. Rasor, Harold K. Treece.

Hardin County—Stephen P. Churchill, Richard A. Dietrich, Floyd M. Elliott.

Harrison County—George E. Henderson.

Henry County—Wilson J. Stough, Thomas F. Tabler.

Highland County—J. C. Bohl, J. Martin Byers, Robert G. Claeys, Walter Felson, Clifford G. Foor, W. M. Hoyt, William C. Martindill, George Lyle Morris, Jacob Wacker, William H. Willson.

Hocking County—Charles T. Grattidge, Richard C. Jones, Jan S. Matthews, L. W. Starr, George B. Watson.

Huron County—Nino M. Camardese, Clyde J. Cranston, Otto F. Lanka, Owen J. Nicholson.

Jackson County—John M. Cook, Clarence C. Fitzpatrick, Claude S. Hambrick, Louis J. Jindra, Earl J. Levine, Harold W. Long, W. T. Washam.

Jefferson County—Stanley L. Burkhardt, Carl F. Goll.

Knox County—John L. Baube, Anthony Garlisi, Robert H. Hoecker, Henry T. Lapp, Raymond S. Lord, Alexander S. Mack, James C. McLarnan, Thomas M. Prescott, Gordon H. Pumphrey, Irville S. Rian.

Lake County—Joseph W. Koelliker, Jr., Benjamin S. Park, Paul E. Reading.

Lawrence County—Anne M. Alstott, Leland S. Dillon, Gerard C. Geswein, Raymond D. Kimbrough, Leo S. Konieczny, Harry Nenni, Robert G. Smith, George N. Spears.

Licking County—Charles S. Baldwin, William V. Banning, Geraldine H. Crocker, Gerald A. Erhard, Kurt J. Fleisch, Carl M. Frye, George H. Gressle, Robert C. Haubrich, R. Gilbert Mannino, Hector C. McKnew, Jr., Lawrence H. Miller, James K. Nealon, Carl L. Petersilge, Arnold D. Piatt, Ralph E. Pickett, R. G. Plummer, D. A. Skinner, Grover B. Swoyer, J. R. Wells.

Logan County—Douglas W. Beach, George H. Freetage, Hobart L. Mikesell, Clyde K. Startzman, Charles H. Thompson, John B. Traul, Ralph K. Updegraff, Jr.

Lorain County—Charles R. Meek, Ben V. Myers, Oscar H. Schettler, James T. Stephens, Jeanne H. Stephens, Rudolph A. Styblo, George R. Wiseman.

Lucas County—Richard F. Baer, George N. Bates, Albert L. Bershon, Henry A. Burstein, Henry D. Cook, John D. Dickie, Crawford L. Felker, John P. Gardiner, Edmond F. Glow, Warren W. Green, Joseph M. Hertzberg, James Howard Holmes, Richard Hotz, C. E. Hufford, David M. Katchka, J. Lester Kobacker, Rollin W. Kuebbeler, Adelbert J. Kuehn, Gustave S. Link, Kenneth C. McCarthy, Edward James McCormick, F. N. Nagel, Edward F. Ockuly, Frederick P. Osgood, Frank F. A. Rawling, Maurice A. Schnitker, Max T. Schnitker, Byron G. Shaffer, Howard E. Smith, J. Hugh Webb, Willis J. Wendler, Jr., Randolph P. Whitehead, Charles S. Wohl.

Madison County—Sol Maggied, John M. Morse, F. E. Rosnagle.

Mahoning County—Leon L. Bernstein, Leonard P. Caccamo, William H. Evans, Charles N. Giering, Carl A. Gustafson, Francis G. Kravec, Paul J. Mahar, DeForest W. Metcalf, A. W. Miglets, Rollis R. Miller, Stephen W. Ondash, Cary S. Peabody, Alexander K. Phillips, R. B. Poling, Asher Randell, Fred G. Schlecht, Ivan C. Smith, Edward M. Thomas, Oscar A. Turner, Elmer J. Wenaas, William P. Young.

Marion County—Daniel W. Brickley, Jr., Karl H. Feistkorn, Albert D. Kapcar, Paul E. Lyon, Donald H. MacPherson, James A. McGlew, Daniel M. Murphy, Morten S. Olson, E. T. Sager, Jack F. Smyth, T. H. Sutherland, Ransome R. Williams.

Medina County—Richard W. Avery, William G. Halley, Nevin J. M. Klotz, Horatio T. Pease.

Meigs County—Roger Parry Daniels.

Mercer County—Paul E. Beare, Ralph J. Beare.

Miami County—William N. Adkins, Harold Car

ter, Berton M. Hogle, Dale A. Hudson, Kenneth F. Lowry, Edmond G. Puterbaugh, Harry E. Shilling, Dale R. South, Jr., Robert L. Sutton, William W. Trostel, Gerard F. Wolf, George A. Woodhouse, Ralph D. Yates.

Montgomery County—E. E. Archdeacon, Kenneth D. Arn, Roy D. Arn, Lee Ashmun, Sterling H. Ashmun, Lynne E. Baker, David Louis Bernie, Roy S. Binkley, A. V. Black, Morton E. Block, Robert E. Boswell, Russell N. Brown, Herbert R. Cammerer, Arthur W. Carley, Everett F. Conlogue, Sydney H. Dinkin, Roscius C. Doan, R. Dean Dooley, John M. Duchak, Stanley A. Earley, Jr., Harry Einhorn, Richard S. Graves, Francis V. Grice, Carl H. Hall, William H. Hanning, Jerome P. Hochwalt, Paul E. Kaufmann, Richard S. Koehler, Albert F. Kuhl, Kenneth Kurtz, Howard Lauer, Raymond A. Lewis, Hans Liebermann, Theodore L. Light, William R. Love, Charles G. Lovingood,

Gerald E. Meyer, Kenneth L. Meyers, Richard C. Miller, Thomas E. Newell, Charles B. Phillips, Joseph H. Prince, Merrill D. Prugh, Jack M. Randall, James A. Rodeghero, Louis Ryterband, Harry B. Schiffer, Alan D. Shafer, Everett W. Shank, Martin L. Sherman, William L. Slagle, E. Wallace Smith, Nathaniel Soifer, W. V. Stinson, Henry L. Strohmeyer, G. Douglas Talbott, Nicholas J. Thompson, Arthur M. Tiber, Jack W. Weiland, Kenneth A. Welty, Homer H. Williams, Giles Wolverton, John Worthman.

Morgan County—Henry Bachman, C. E. Northrup, Asia H. Whitacre.

Morrow County—David J. Hickson, Joseph P. Ingmire, Francis W. Kubbs, William Lowell Murphy.

Muskingum County—J. Herbert Bain, Rolland D. Bateman, Charles I. Cerney, Richard D. Davis, Walter B. Devine, Peter A. Fomenko, Robert S. Martin, James E. McCormick, Alfred C. Ormond, Charles L. A. Wehr, Earl B. Zurbrugg.

Noble County—Edward G. Ditch.

Ottawa County—George A. Boon, Cyrus R. Wood.

Paulding County—Doyt E. Farling.

Perry County—Alton J. Ball, Charles E. Bope, Sydney N. Lord, Charles B. McDougal.

Pickaway County—F. W. Anderson, Warren R. Hoffman, Vemont D. Kerns.

Pike County—Robert M. Andre, George W. Cooper, Cecil L. Grumbles, Paul H. Jones, Albert M. Shrader.

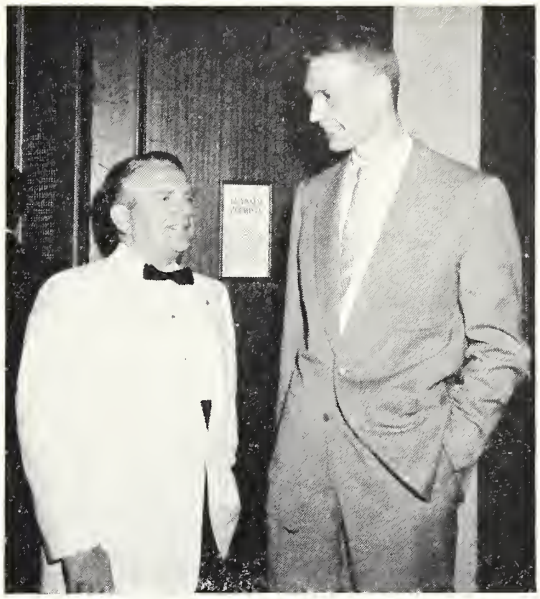
Portage County—Hildreth B. Elwell, Jr., Arthur L. Knight, Edward T. Meacham, Myron S. Owen, David S. Palmstrom, Max Sternlieb, Myron W. Thomas, Edward A. Webb.

Preble County—C. J. Brian.

Putnam County—Alphonse V. Armbruster, Milo B. Rice.

Richland County—Russell H. Barnes, C. H. Bell, Stanley L. Brody, Charles O. Butner, Rundle D. Campbell, John J. Clark, Carl R. Damron, Carroll E. Damron, Joseph B. Edelstein, Virginia S. Edwards, Robert L. Garber, Oscar W. Klein, Harlin G. Knierim, William Richard Roasberry, Robert P. Scott, Joseph E. Seibert, John O. Smith, P. O. Staker, Robert W. Tawse, Lawrence C. Thompson, Francis M. Wadsworth, Harry Wain, Hall S. Wiedemer, Ralph C. Wise.

Ross County—Edwin H. Artman, Charles A. Clifton, Lewis W. Coppel, Richard L. Counts, Ernest B. Cutlip, Theodore Cutright, William M. Garrett, Robert P. Giesler, Ralph W. Holmes, Walter E. Kramer, Paul F. MacCarter, Jr., David McKell, A. E. Merkle, Francis Wayne Nusbaum,



President Meiling welcomes as guest of the Association Robert Rakel, University of Cincinnati junior medical student who has recently been installed as president of the Student American Medical Association.

M. Dow Scholl, Byron Stinson, Robert E. Swank, Joseph Utrata, Adolf Wolff.

Sandusky County—Charles L. Fox, Robert C. Fox.

Scioto County—Walter A. Braunlin, Clyde W. Everett, Clyde M. Fitch, A. P. Hunt, Milton Levine, Ralph W. Lewis, G. E. Neff, Carter L. Pitcher, Jerome M. Rini, William E. Scaggs, William M. Singleton, Walter H. Sisson, Oral D. Tatje.

Seneca County—Henry L. Abbott, Stephen R. Markey, James L. Murphy.

Shelby County—Richard H. Breece, H. Eugene Crimm, Boyd L. Mahuron, George J. Schroer, James W. Tirey.

Stark County—Alfons Cecys, William R. Farrar, Loren L. Frick, Joseph K. Gyalai, Robert R. Hirst, William A. McCrea, John W. McFadden, Keith C. Noble, Otto L. Plaut, Ralph K. Ramsayer, Don L. Ream, Ralph L. Rutledge, Paul C. Schwallie, John R. Seesholtz, Lloyd M. Snively, Richard G. Spitzer, James J. Thomas, John F. Thompson, Robert E. Tschantz, Lee C. Underwood, William A. White, Jr., George M. Wilcoxon, L. W. Zadinsky, Harold C. Ziegler.

Summit County—William C. Baird, Edwin W. Cauffield, Paul A. Davis, Philip B. DeMaine, Arthur Dobkin, William H. Falor, A. W. Friend, Stephen V. Geroch, John P. Goetz, L. C. Hatch, Keith C. Keeler, Edward W. Kissel, Charles N. Long, Daniel F. Mathias, Daniel W. Mathias, Donald I. Minnig, Harold E. Muller, Howard O. Musser, Carl C. Nohe, John G. Repasky, Harold M. Schwarz, Donald M. Traul, E. L. Voke, Frank M. Warner, Rex H. Wilson, Louis A. Witzeman.

Trumbull County—Charles A. Anderson, Edward E. Bauman, Maynard A. Buck, Gene D. Fry, Marie B. Krupko, Paul E. Krupko, Clyde W. Muter, Joseph A. Ralston, Sigmond J. Shapiro, Densmore Thomas, Edwin R. Westbrook.

Tuscarawas County—Chester A. Bennett, C.

Raymond Crawley, Philip T. Doughten, DeLoise H. Downey, Morrison W. Everhard, Joseph W. Hamilton, Roy D. Hildebrand, Robert B. Hines, Daniel D. Hostetler, William E. Hudson, H. J. Reamy, Robert E. Rinderknecht, Elizabeth Rowland - Aplin, Arthur J. Stevenson, Herbert F. Van Epps.

Union County—Fred C. Callaway, Bernard E. Ingmire, Herman E. Karrer, E. J. Marsh, James M. Snider, Harry G. Southard.

Van Wert County—Edwin W. Burnes, Jack H. Cox, Alford C. Diller, James R. Jarvis, Harold C. Smith.

Vinton County—Herbert D. Chamberlain.

Warren County—O. Willard Hoffman, Dale D. Hubbard, Orville L. Layman, David P. Ward.

Washington County—Kenneth E. Bennett, Ford E. Eddy, George E. Huston, Edgar Northrup.

Wayne County—Bernard M. Foster, James Wylie McGough, Lincoln L. Moore, John M. Robinson.

Williams County—H. R. Mayberry, Paul G. Meckstroth, John R. Riesen.

Wood County—Henry W. Dierksheide, Francis J. Nemcik, Paul F. Orr, Roger A. Peatee, Halford E. Whitacre.

Wyandot County—Richard L. Garster, Talmadge R. Huston, Allen F. Murphy, Franklin M. Smith, John M. Thompson, Harlow K. Van Buren.

AMA Public Relations Institute In Chicago, August 28-29

Those actively engaged in medical public relations should plan to attend the American Medical Association's 1957 Public Relations Institute, August 28 - 29, at the Drake Hotel, Chicago. Wednesday morning's program will be a search of solutions to three problems of medicine and publicity: (1) Problems of science writers in developing stories of national significance; (2) Problems of the working press in covering local medical news, and (3) Ethical considerations of distinguishing between advertising and legitimate medical news.

AMA's new film for the public—"Whitehall 4-1500"—will be premiered during Wednesday's luncheon, and the "Mechanical Quackery" slidefilm also will be shown. In the afternoon, state and county representatives will split up into four groups—according to size of society—to discuss mutual public relations problems.

Thursday morning's program will include a panel discussion on the present status of grievance committees and how they can work more efficiently. Other discussion topics will be selected later. The one-and-a-half day meeting will wind up with a luncheon featuring an outstanding guest speaker to be announced later.

Dr. Sidney Franklin, Youngstown, addressed the annual convention of The American Board of Legal Medicine at St. Moritz Hotel, New York City, on June 1, on the subject "Problems of Senility" and on the following day, he was re-elected vice-president of the Board for the Central Area.

Doctors' Draft Act To Die; New Measure Enacted

As this issue went to press, the bill, H. R. 6548, to provide a substitute procedure for the Doctors' Draft Act which will expire on June 30, had been passed by both House and Senate and was awaiting the President's signature. Under the new law beginning July 1, the four priorities will be no more and special registration of physicians, dentists and veterinarians will be discontinued. Retained from old doctor-draft law are provisions for an advisory committee to Selective Service; appointment of physicians and dentists to rank commensurate with training, experience and ability; utilization of doctors as enlisted men if they refuse or fail to qualify for commissions. The new law simply authorizes President to issue special calls for physicians, dentists and allied specialists who are liable for induction under regular draft program.

AMA Television Programs Win Awards

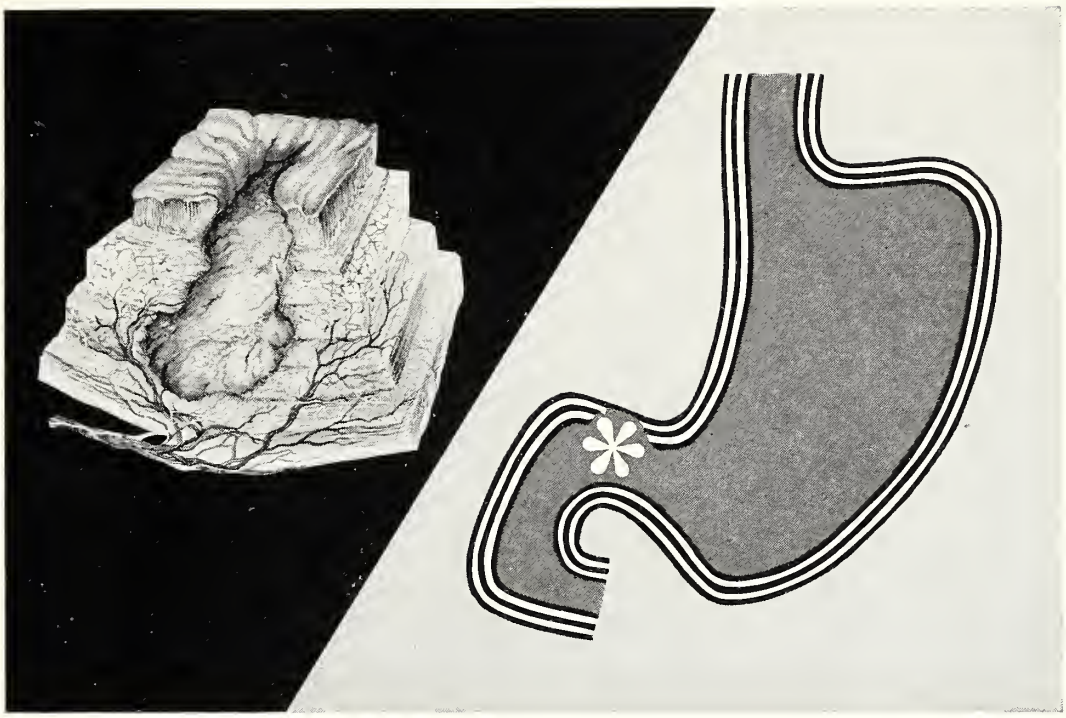
Medicine is making a name for itself in the world of television. Recently, three AMA-sponsored programs walked off with national and local awards in competition with commercially-sponsored programs. At the fourth American Film Assembly sponsored by the Film Council of America, AMA's newest TV film "Even for One" received the Golden Reel Award in the institutional promotion category. "Monganga" — a filmed report on a medical missionary which was produced by Smith, Kline & French Laboratories in cooperation with AMA—received the Silver Reel Award at the same show.

Locally, AMA's second series of 26 programs for "Baby Time" received the Chicago Federated Advertising Clubs top award for "outstanding achievement in advertising by Chicago talent." The honor was made jointly to the AMA and Herbert S. Laufman and Co., the producers. The AMA's Bureau of Health Education announces that 13 selected films from this series are being made available for a period of one year, without charge, to medical societies for placement on local public service time.

Twenty-Five Years From Now?

What will living be like 25 years from now? The magazine, *Changing Times*, answered that question in a recent article entitled "Look 25 Years Ahead—Great Changes Coming." The article touched on almost every phase of life. Under the subhead "Health," the magazine said: "Medical bills will be paid for in advance, through insurance and prepaid plans. But it doesn't look as if compulsory health insurance under government auspices is in the cards."

BROAD ANTICHOLINERGIC BLOCKADE



Pro-Banthine® Relieves Pain, Accelerates Peptic Ulcer Healing

The efficiency of Pro-Banthine (brand of propantheline bromide) in inhibiting the chemical substance which mediates parasympathetic gastric activity explains the success of the drug in ulcer therapy. Pro-Banthine blocks acetylcholine at both the ganglia and parasympathetic effector sites. This dual action controls excess neural stimulation of both gastric secretion and motility.

The therapeutic benefits of this anticholinergic blockade consist, as many clinical investigators have noted, in prompt relief of ulcer pain and pronounced acceleration of ulcer healing.

The suggested initial dosage is one 15-mg. tablet with meals and two tablets at bedtime. Two or more tablets four times a day may be indicated in severe manifestations. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

SEARLE

Woman's Auxiliary Annual Meeting . . .

Excellent Results Are Announced Following 17th Annual Convention In Columbus; Attendance Reaches 378; Report on Various Projects

THE 17th Annual Convention of the Woman's Auxiliary to the Ohio State Medical Association convened in the Deshler-Hilton Hotel on Tuesday afternoon, May 14.

The first afternoon session was a School of Instruction for all members of the Auxiliary, with the program title "Who, How, and Why in Medical Auxiliary" or "Stump the Experts." Moderated by Mrs. C. H. Bell, 1st Vice-President, the first panel considered "who we are and what we do." The experts serving on the panel were past-presidents of the Woman's Auxiliary. The second panel was moderated by Mrs. W. R. Gibson, second Vice-President, who discussed the problem of how we carry out our aims and objectives. The panel of experts was composed of state chairmen. The third portion of the program was presented by Attorney William T. Gillie, first assistant city attorney, Columbus, who discussed "Parliamentary Procedure—But Why?" Mr. Gillie gave an excellent background of parliamentary procedure and its development from the British parliamentary form. He illustrated graphically its great function in voluntary organizations, i. e. to see that all business is conducted fairly, speedily, and in such a manner as to carry out the will of the majority, while yet hearing the viewpoint of the minority.

Following the School of Instruction, Mrs. C. William O'Neill, the wife of Ohio's Governor, was a most gracious hostess for tea at the Governor's Mansion.

The formal opening of the Convention body, House of Delegates, took place on Wednesday morning on May 15 with Mrs. William H. Evans, president, presiding. During this session a resolution supporting House Bill 384, which would amend the present law to allow dog pounds to sell to recognized research centers unwanted and unclaimed dogs, was discussed and unanimously passed by the House of Delegates.

DOCTORS' DAY LUNCHEON

At noon on Wednesday doctors throughout the state were honored at the Doctors' Day Luncheon. Dr. Richard L. Meiling, then President of the Ohio State Medical Association, addressed the group. This talk was followed by three humorous skits arranged by the Auxiliary to the Columbus Academy of Medicine.

The Wednesday afternoon general session continued the School of Instruction of Tuesday afternoon—in a fascinating way. Mrs. C. A. Colombi, third vice-president, was responsible for this program entitled "Information Please" and presented a musical show "Doctor, This is Your Wife." The entire show was written and produced by the members of the Woman's Auxiliary to the Cleveland and Cuyahoga County Academy of Medicine. The humorous skit enhanced the excellent ideas and information contained therein. Following the musical show, colored slides depicting "Auxiliaries in Action" again emphasized how Auxiliaries may carry out their projects on a local level.

During the Thursday morning session of the Convention, several resolutions were presented. One of particular interest was a resolution supporting the Jenkins-Keogh Bill. Another expressed the Auxiliary's support, continued interest, and participation in soundly formulated mental health programs; expansions of psychiatric wards in general hospitals; expansion and improvement of mental hospitals; increased numbers of volunteers in state hospitals; and the promoting of scholarships to encourage students to enter the fields of psychiatric nursing, social work, etc.

ATTENDANCE FIGURES

The final roll call as reported by Mrs. Henry B. Lacey showed in attendance at the Convention, 38 board members, 102 delegates, 30 alternates, 196 members, 11 guests, and one member-at-large for a total registration of 378.

It was the privilege of members to have present Mrs. Robert Flanders, President of the Woman's Auxiliary to the American Medical Association, who spoke on "The Auxiliary, Your's and Mine." Mrs. Flanders reiterated her theme and challenged those present as Auxiliary members to uphold her slogan "Health is Our Greatest Heritage." Following her address, Mrs. Flanders installed the new officers.

Mrs. V. R. Frederick's inaugural address emphasized our duties toward doctor-husbands as well as the medical profession in general and set forth Ohio's theme for the year, "United Service to God and Man."

Following the Orchid Luncheon on Thursday, Mrs. William H. Evans presented to Mrs. Flanders the Auxiliary's check for over $10,100 which represented the Ohio Auxiliary's contribution to the American Medical Education Foundation Fund. Mrs. Evans also presented the Woman's Auxiliary to the Ohio State Medical Association Nurse Education Fund check in the amount of $1,000 as a grant to Miss Roselyn Wealth. Miss Wealth, graduate nurse, serving in Cincinnati General Hospital, indicated that she intended to use the grant, made to enable her to do further

Ohio Auxiliaries Contribute To AMEF Fund



Mrs. Robert Flanders, left, president of the Woman's Auxiliary to the American Medical Association, receives a check for $10,100 for the American Medical Education Foundation fund from the Auxiliaries in Ohio. Making the presentation is Mrs. William H. Evans, immediate past-president of the Ohio Auxiliary. There are now 60 organized Auxiliaries in Ohio with a combined membership of more than 5,000.

graduate study, in the field of psychiatric nursing. A delightful program of Hawaiian song and dance concluded the 1957 Convention.

ACHIEVEMENTS

The year 1956-1957 was a year of achievement for the Auxiliary under the presidency of Mrs. William H. Evans. The membership of 5,083 represents the greatest number of doctors and wives ever to be active in Auxiliary work. The contribution of $10,100 plus to the American Medical Education Foundation Fund was the greatest in the history of the AMEF project in Ohio, (second only to Texas in the Nation). During the Convention, Mrs. W. R. Farrar, state AMEF Chairman, presented, for the first time, state awards for AMEF contributions determined on a percentage per member basis. Columbiana County received first place in the State of Ohio; Butler County, second; and Huron County, third. In addition, five counties received National award for having contributed $1,000 or more to the Fund—Cuyahoga, Franklin, Hamilton, Lucas, and Stark.

Ohio's record in the distribution of *Today's Health*, an Auxiliary priority project assigned by the AMA, resulted in the following awards, presented by Mrs. James Greetham, state chairman for *Today's Health* to four counties. Huron County, with 2,436 per cent of their quota, not only won first place in Ohio's contest for Auxiliaries from 1 to 35 in membership, but also won the National Award in this membership category. Allen County won Ohio's award for Auxiliaries with a membership of 36 to 75 with 261 per cent of quota. Clark County, in the membership group 76 to 100, received first place with 237 per cent of its quota. In the group having over 100 members, Mahoning County was the first place winner with 183 per cent of quota.

Mrs. V. R. Frederick awarded Certificates of Achievement to the following counties for over-all

Auxiliary Promotes Nursing Scholarship



In the center is Miss Roselyn Wealth, College of Nursing and Health, University of Cincinnati, receiving a $1,000 Scholarship for postgraduate work from Mrs. William H. Evans, Youngstown, right, immediate past-president of the Woman's Auxiliary to the Ohio State Medical Association. At the left is Miss Louise Flynn, Children's Hospital, Cincinnati, chairman of the Scholarship Committee, Ohio League for Nursing.

achievements as reported on Credits and Awards sheets of activities throughout the year. Counties with 17 or fewer members, Ottawa County; Auxiliaries of 18 to 30 members, Belmont County; 31 to 50 members, Tuscarawas and Columbiana Counties, tied; 51 to 100 members, Butler County; and for Auxiliaries with over 100 members, Lucas and Franklin tied.

New Board Requirements

Announcement by the American Board of Radiology states that candidates who started their residency in 1956 will be expected to devote three years to formal residency training in an approved department of radiology, plus one year of practice or additional training in order to be eligible to appear for examination by the American Board of Radiology.

Those individuals who may be called to military duty during their residency and have been assigned to a department of radiology for one year or more, may substitute this time for the required one year of practice or additional training.

All candidates for examination after 1956 must have received three years' formal, approved residency training regardless of military duties.

OSU College of Medicine Announces Appointments

Promotions of two staff members in the College of Medicine to department chairmanships were announced by the Board of Trustees of Ohio State University. Both are effective July 1.

Dr. John B. Brown becomes chairman of the Department of Physiological Chemistry and Pharmacology, succeeding Dr. Clayton S. Smith who is retiring.

Dr. Linden F. Edwards heads the Department of Anatomy, to succeed Dr. Ralph A. Knouff, who asked to be relieved of administrative duties to devote his time to teaching and research.

All four men are veteran members of the university faculty. Dr. Brown has been a staff member since 1924. Since 1950 he also has been director of the University's Institute of Nutrition and Food Technology. Dr. Edwards holds three degrees from Ohio State and joined the staff of the Department of Anatomy as assistant professor in 1929.

Dr. Smith retires from the university after 37 years of service. Dr. Knouff's period of service on the staff spans 40 years. He has been professor of anatomy and chairman since 1931.

AMA House of Delegates . . .

Ohio Delegates Take Prominent Part in Proceedings at New York Meeting, June 3-7; Actions Taken on Numerous Important Matters

REVISION of the Principles of Medical Ethics, relations with the United Mine Workers of America Welfare and Retirement Fund, the Medicare program, new standards for medical schools, a new statement on occupational health programs and the issue of Social Security benefits for physicians were among the wide variety of subjects acted upon by the House of Delegates at the American Medical Association's 106th Annual Meeting held June 3-7 in New York City.

OHIO DELEGATES PROMINENT

Ohio's delegates took a prominent part in the sessions. Dr. C. C. Sherburne, Columbus, served as chairman of the important Reference Committee on Amendments to the Constitution and By-Laws. Dr. Carll S. Mundy, Toledo, and Dr. L. H. Schriver, Cincinnati, were members, respectively, of the Reference Committee on Insurance and Medical Service and Reference Committee on Executive Session.

Two of Ohio's four resolutions were introduced by Dr. R. L. Meiling, Columbus; one by Dr. George A. Woodhouse, Pleasant Hill; and one by Dr. Charles L. Hudson, Cleveland. Dr. Hudson was one of several nominees for vacancies on the Council on Medical Education and Hospitals but was not elected.

Other delegates representing the OSMA were Dr. Paul A. Davis, Akron, and Dr. Fred W. Dixon, Cleveland. Also from Ohio was Dr. Charles L. Leedham, Cleveland, representing the Section on Military Medicine. The delegate representing the United States Public Health Service was Dr. John D. Porterfield, formerly from Ohio, substituting Dr. L. E. Burney, surgeon general of the USPHS. Reference is made in this article to the disposition of the four Ohio resolutions.

GUNDERSEN ELECTED

Dr. Gunnar Gundersen of La Crosse, Wis., member of the A. M. A. Board of Trustees since 1948 and chairman for the past two years, was unanimously chosen president-elect for the year ahead. Dr. Gundersen, who also was first chairman of the Joint Commission on Accreditation of Hospitals from 1951 to 1953, will become president of the American Medical Association at the June, 1958, meeting in San Francisco. There he will succeed Dr. David B. Allman of Atlantic City, N. J., who was installed as the 111th president at the New York meeting.

SPIES IS HONORED

The House of Delegates voted the 1957 Distinguished Service Award of the American Medical Association to Dr. Tom Douglas Spies, formerly of Cincinnati, now head of the department of nutrition and metabolism at Northwestern University Medical School, Chicago, and director of the nutrition clinic at Hillman Hospital, Birmingham Alabama, for his outstanding contributions to the science of human nutrition.

NEW PRINCIPLES OF MEDICAL ETHICS

The House approved the long-discussed revision of the Principles of Medical Ethics, originally submitted at the 1956 annual meeting in Chicago. The final version, presented by the Council on Constitution and Bylaws and then amended by reference committee and House discussions in New York, now reads as follows:

"These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

"**Section 1.**—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

"**Section 2.**—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

"**Section 3.**—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

"**Section 4.**—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

"**Section 5.**—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

"**Section 6.**—A physician should not dispose

of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

"Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

"Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

"Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

"Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community."

REAFFIRM GUIDES

In approving the new Principles of Medical Ethics, the House of Delegates also reaffirmed the "Guides for Conduct for Physicians in Relationships with Institutions," adopted in 1951, and requested the Board of Trustees to devise and initiate a campaign to educate both physicians and the general public to the dangers inherent in the illegal corporate practice of medicine in its various forms.

The Judicial Council of the AMA is preparing a digest of previous rulings and interpretations of the Principles of Medical Ethics over the years. This will be available for interpretations of the new principles and for application of the new principles to future situations and cases.

OHIO RESOLUTION NOT APPROVED

One of Ohio's resolutions, introduced by Dr. Hudson for the OSMA on order of the OSMA House of Delegates and numbered No. 21, had to do with Section 6 of the Principles. It requested that Section 6 be amended to read as follows:

"A physician should not dispose of his services under terms or conditions which (1) interfere with or impair the free and complete exercise of his independent medical judgment and skill, (2) cause deterioration of the quality of medical care, (3) or permit the sale of his professional services by any lay person or corporation."

The reference committee stated that it was in complete accord with the objectives of the Ohio resolution but recommended that it not be adopted for reasons stated in the following portion of the reference committee's report:

"The basic function of the Principles of Medical Ethics, in the area being considered in Section 6, is to prevent conditions which (a) interfere with or impair the free and complete exercise of a physician's independent medical judgment and skill, or (b) may cause deterioration in the quality of medical care. The Principles are not designed to correct these faults after they have occurred or specifically to enumerate the myriad of conditions which may, in our judgment, have this effect:

QUOTATION FROM GUIDES

"Many of the specific instances which may adversely affect the quality of medical care have already been defined by the House of Delegates. No doubt, as other such situations arise, cognizance of them will be taken by this body. Notable among these pronouncements is the "Guides for Conduct for Physicians in Relationships with Institutions" adopted by the House of Delegates in 1951. It is recommended that this action of the House of Delegates be herewith reaffirmed. Included in such "Guides" are the following:

> " 'The primary obligation of both physicians and hospitals is to serve the best interest of the patients. The decision as to the ethical or unethical nature of practice must be based on the ultimate effect for good or ill on the public as a whole. All of the various questions involved in the relationship between physicians and hospitals, both legal and ethical, particularly questions dependent on local conditions, must be considered in the first instance at the local level because of the various differences which of necessity exist in the many sections of the country.
>
> " 'In summary, the following general principle(s) are suggested to individual physicians, county medical societies, and state medical associations on the basis for adjusting controversies, these principles, however, to be qualified to the extent required by the applicability of one or more of the factors heretofor mentioned:
>
> " '1. A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.'

DIFFICULT TO INTERPRET

"The report of the Council on Constitution and Bylaws included, within the proposed Section 6,

a phrase prohibiting a physician from disposing of his services under terms or conditions permitting the "exploitation of his services for financial profit." The term "exploitation" is thought by many to be difficult to define and in many instances would require a financial audit to prove its existence. This is not in our judgment a proper basis for determining an ethical standard. The "Guides" previously referred to, and hereby recommended for your reaffirmation, make it clear that the type of financial arrangement between a physician and a hospital, corporation or other lay body is important and relevant in determining whether or not such an arrangement is ethical. We further believe that the amount of a physician's income or whether or not an institution is making a profit on his services is irrelevant in determining whether an arrangement is ethical.

SUBSTITUTE RECOMMENDED

"To emphasize the preventive ideal, to remove economic criteria and to maintain, without specific particularization, the broad ethical concepts which should be contained in the Principles of Medical Ethics, your reference committee recommends that the following Section 6 be substituted for the Section 6 proposed in resolution No. 21 and by the Council on Constitution and Bylaws:

> " 'Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.'

RE CORPORATE PRACTICE

"The Ohio Resolution (No. 21) appears to be aimed at the illegal corporate practice of medicine to which this House has repeatedly expressed its opposition. Those appearing before the Committee were virtually unanimous in their condemnation of corporate medical practice.

"Your Committee is in agreement with the majority of the sentiments expressed and is disturbed by the probable deleterious effects of the corporate practice of medicine upon the future of medicine and the care of patients. In many of its forms, it is indistinguishable in practice and effect from socialization of medicine and appears to embody all of its evils.

"Your reference committee is impressed by the necessity of informing all physicians and the general public as to the evils which may be inherent in the socialization of medicine through corporate activity as well as by government action.

EDUCATIONAL CAMPAIGN URGED

"Your reference committee therefore recommends that this problem be referred to the Board of Trustees with the request that it devise and initiate a campaign to educate both physicians and the general public as to the dangers inherent in the illegal corporate practice of medicine in its various forms.

"The committee wishes to call attention again to the annotated volume of past decisions of the Judicial Council which will be helpful in the interpretations of the revised Principles of Medical Ethics, copies of which will be available shortly."

GUIDES FOR RELATIONS WITH UMWA FUND

In a key action on the basic issue of third-party intervention, as it affects the patient's free choice of physician and the physician's method of remuneration, the House adopted the "Suggested Guides to Relationships Between State and County Medical Societies and the United Mine Workers of America Welfare and Retirement Fund," which were submitted by the A. M. A. Committee on Medical Care for Industrial Workers. In approving the guides, the House also recommended that the Board of Trustees study the feasibility and possibility of setting up similar guides for relations with other third-party groups such as management and labor union plans.

The statement, which outlines both medical society and UMWA responsibilities, contains these "General Guides":

> "1. All persons, including the beneficiaries of a third-party medical program such as the UMWA Fund, should have available to them good medical care and should be free to select their own physicians from among those willing and able to render such service.
>
> "2. Free choice of physician and hospital by the patient should be preserved:
>
> "a. Every physician duly licensed by the state to practice medicine and surgery should be assumed at the outset to be competent in the field in which he claims to be, unless considered otherwise by his peers.
>
> "b. A physician should accept only such terms or conditions for dispensing his services as will insure his free and complete exercise of independent medical judgment and skill, insure the quality of medical care, and avoid the exploitation of his services for financial profit.
>
> "c. The medical profession does not concede to a third party such as the UMWA Welfare and Retirement Fund in a medical care program the prerogative of passing judgment on the treatment rendered by physicians, including the necessity of hospitalization, length of stay, and the like.
>
> "3. A fee-for-service method of payment for physicians should be maintained except under unusual circumstances. These unusual circumstances shall be determined to exist only after a conference of the liaison committee and representatives of the Fund.
>
> "4. The qualifications of physicians to be on the hospital staff and membership on the hospital staffs is to be determined solely by local

hospital staffs and by local governing boards of hospitals."

MEDICARE PROGRAM

The House considered three resolutions dealing with the Federal Government's Medicare program, one of them being the Ohio resolution, No. 19. The Ohio resolution as introduced by Dr. Meiling, on order of the OSMA House of Delegates, read as follows:

"WHEREAS, the Medicare Program now being carried on under the provisions of Public Law 569, 84th Congress is being administered as a service type medical care program, and

"WHEREAS, this program interferes with the time honored physician-patient relationship as it does not permit a physician to establish his own fee for his professional services to the dependents of servicemen but compels him to accept the fee allowed by the Federal Government if he accepts a patient under the program, therefore

"BE IT RESOLVED, That the American Medical Association request the Secretary of Defense to modify the Medicare Program regulations so that the program can be operated as an indemnity type program or that the American Medical Association, if necessary, take steps to have Public Law 569, 84th Congress, amended so such program can be carried on as an indemnity program."

OHIO RESOLUTION ENDORSED IN PRINCIPLE

The report of the Reference Committee on Insurance and Medical Service on this subject, which was adopted by the House of Delegates without a dissenting vote, strongly supported the substance of the Ohio resolution opposing fixed fee schedules and advocating that the Medicare regulations be modified so the program can be operated as an indemnity type program where desired. Following is the text of the reference committee's report on the Ohio resolution as adopted by the AMA House of Delegates:

"In considering this resolution the reference committee was advised that in preliminary discussions with the Department of Defense relative to Administrative Regulations that representatives of the American Medical Association had expressed the opinion that:

"(a) The Dependent Medical Care Act as enacted by Congress does not necessitate the establishment of fixed fee schedules in the implementation of the program;

"(b) The establishment of fixed fee schedules would result in a more expensive program than if physicians were permitted to charge their regular normal fees; and

"(c) The establishment of such fee schedules would ultimately disrupt the economics of medical practice.

"Administrative Regulations as finally adopted did not incorporate the above suggestions of the American Medical Association and the contracts finally negotiated by all but two of the state medical societies include a negotiated fixed fee schedule.

SHOULD LEAVE DECISION TO STATES

"This committee realizes that the full service concept is contrary to the adopted policies of various of the state medical societies. Your committee believes that the objectives contemplated in resolution 19 would be attained if the suggestions made by the American Medical Association in the original negotiations referred to above were adopted. In fact we have been informed that several states have negotiated a contract without a published fee schedule. We are not recommending approval of resolution 19 as presented but instead are recommending that the decision as to the type of contract and whether or not a fee schedule is included in future contract negotiations should be left to individual state determination and that the American Medical Association request the Secretary of Defense to modify the Medicare Program regulations and directives so that the program can be operated as provided by Public Law 569, as an indemnity type program where desired."

The delegates adopted a resolution condemning any payments under the Medicare program "to or on behalf of any resident, fellow, intern or other house officer in similar status who is participating in a training program." Government sanction of such payments, the House declared, would give impetus to the improper corporate practice of medicine by hospitals or other nonmedical bodies. Such proposals, the House added, would violate traditional patterns of American medical practices, seriously aggravate problems of hospital-physician relationships, encourage charges by hospitals for residents' services to patients not under the Medicare program, and create a variety of additional problems in such areas as medical licensure and health insurance.

In another action on Medicare, the House suggested that the A. M. A. attempt to have existing Medicare regulations amended to incorporate the Association's policy that the practice of anesthesiology, pathology, radiology and physical medicine constitute the practice of medicine, and that fees for services by physicians in these specialities should be paid to the physician rendering the services.

NEW STATEMENT ON MEDICAL SCHOOLS

To replace the "Essentials of an Acceptable Medical School," initially approved by the House of Delegates in 1910 and most recently revised in 1951, the House adopted a new statement entitled "Functions and Structure of a Modern Medical School." Presentation of the document followed a year of careful study by the Council on Medical Education and Hospitals in collaboration with the Association of American Medical Colleges.

The statement is intended to provide flexible guides which will "assist in attaining medical education of ever higher standards" and "serve as general but not specific criteria in the medical school accreditation program." The document en-

NEW

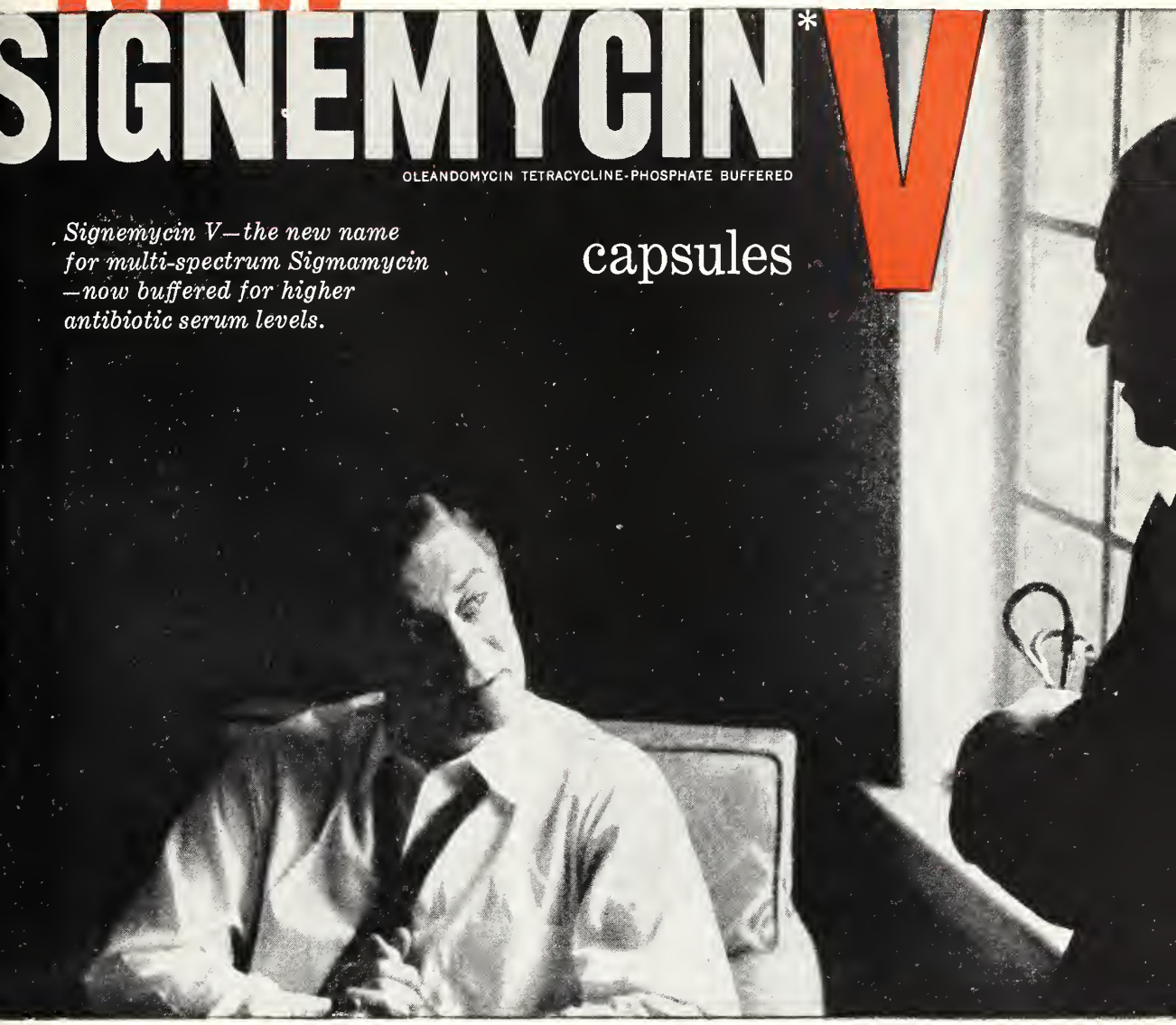
advance in potentiated multi-spectrum therapy—higher, faster levels of antibiotic activity

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courages soundly conceived experimentation in medical education, and it discourages excessive concern with standardization.

"No rigid curriculum can be prescribed for accomplishing the objectives of medical education," it states. "On the contrary, it is the responsibility of the faculty of each school continually to re-evaluate its curriculum and to provide in accordance with its own particular setting and in recognition of advances in science a sound and well-integrated educational program."

OCCUPATIONAL HEALTH PROGRAMS

The House approved a new statement on the "Scope, Objectives and Functions of Occupational Health Programs," submitted through the Board of Trustees by the Council on Industrial Health. The Board report to the House said: "The statement describes and defines orthodox in-plant medical programs as understood in this country today and distinguishes clearly between such programs and the various plans for comprehensive medical care of the sick. It should help to resolve misunderstandings concerning the specialty of occupational medicine."

In adopting the statement, the House agreed with a reference committee report which declared that "the House has before it a statement which for the first time clearly defines the scope, objectives and functions of occupational health programs. It marks the needs and boundaries of occupational medicine. It states in a positive fashion the proper place of occupational health programs in the practice of medicine and it clearly charts the pathways of communication between physicians in occupational health programs and physicians in the private practice of medicine."

SOCIAL SECURITY FOR DOCTORS

Two resolutions favoring compulsory inclusion of physicians in the federal Social Security system and another one calling for a nationwide referendum of A. M. A. members on the issue were rejected by the House. The delegates reaffirmed their opposition to compulsory coverage of physicians under the Old Age and Survivors Insurance provisions of the Social Security Act. They also recommended a strongly stepped-up informational program of education which will reach every member of the Association, explaining the reasons underlying the position of the House of Delegates on this issue. The House at the same time reaffirmed its support of the Jenkins-Keogh Bills.

TWO OHIO RESOLUTIONS REFERRED FOR STUDY

An Ohio resolution introduced by Dr. Woodhouse, advocating the formation of a single national non-government medical research fund under the jurisdiction of physicians, which had been adopted by the OSMA House of Delegates in May, was referred to the Board of Trustees for study and action.

A fourth Ohio resolution, which had been approved by the OSMA House of Delegates and had been introduced by Dr. Meiling, dealing with a proposal to amend the National Atomic Energy Act to exempt licensed physicians from any requirement for a Federal license or permit in order to handle radioactive material, was referred to the Council on Medical Physics for study.

MISCELLANEOUS ACTIONS

In considering 66 resolutions and many additional reports from the Board of Trustees, councils and committees, the House also:

Congratulated the Board and the Committee on **Poliomyelitis** for their prompt action in stimulating national interest in the polio immunization program;

Recommended further study and a progressive program of action, probably including legislative changes, to solve the problem of **narcotic addiction;**

Urged a more careful screening of television and radio patent medicine **advertisements;**

Directed the Board of Trustees to investigate the indiscriminate use of stimulants such as **amphetamine,** particularly in relation to athletic programs;

Directed the Speaker to appoint a committee of five House members to study the **Heller Report,** a management survey of the Association's organizational mechanisms;

Commended the Law Department for its special report on **professional liability** and urged state and county medical societies to establish claims prevention program and to show the new film, "The Doctor Defendant";

Opposed the establishment of any further veterans' facilities for the care of nonservice-connected illnesses of veterans;

Condemned the compulsory assessment of medical men and staff members by hospitals in **fund-raising campaigns;**

ELECTION OF OTHER OFFICERS

In addition to Dr. Gundersen, the new president-elect, the following officers were selected by the House:

Dr. Jesse Hamer of Phoenix, Ariz., vice-president; Dr. George F. Lull of Chicago, secretary; Dr. J. J. Moore of Chicago, treasurer; Dr. E. Vincent Askey of Los Angeles, speaker, and Dr. Louis Orr of Orlando, Fla., vice speaker.

Four new members were elected to the Board of Trustees: Dr. George Fister of Ogden, Utah, to succeed Dr. James R. Reuling; Dr. Cleon Nafe of Indianapolis, Ind., to succeed Dr. James R. McVay; Dr. James Z. Appel of Lancaster, Pa., to replace the late Dr. Thomas P. Murdock, and Dr. Raymond McKeown of Coos Bay, Ore., to replace Dr. Gundersen. Dr. Edwin S. Hamilton of Kankakee, Ill., was elected chairman of the Board at

its organizational meeting after the elections in the House.

Dr. Homer L. Pearson Jr. of Coral Gables, Fla., was renamed to the Judicial Council. Two new members were elected to the Council on Medical Education and Hospitals: Dr. Clark Wescoe of Lawrence, Kansas, to succeed Dr. Weiskotten, and Dr. Warde B. Allan of Baltimore, Md., to succeed Dr. F. D. Murphy of Lawrence, Kansas.

For the Council on Medical Service, Dr. Robert L. Novy of Detroit, Mich., was re-elected, and Dr. Hoyt Woolley of Idaho Falls, Idaho, was chosen to replace Dr. McKeown. Dr. Warren W. Furey of Chicago was re-elected to the Council on Constitution and Bylaws.

At the Wednesday session of the House the Illinois State Medical Society made a record state society contribution to the American Medical Education Foundation by turning over $170,450 to Dr. Louis H. Bauer of New York, foundation president.

Dr. Weech Honored

Dr. A. Ashley Weech, University of Cincinnati College of Medicine, was bestowed one of the 1956 Borden Awards for outstanding research in the nutrition and development of infants and children. The award, administered by the American Academy of Pediatrics, is one of eight special category awards, each carrying with it a gold medal and $1000.

Governor Signs Bill To Make Unclaimed Dogs Available for Medical Research

Am. House Bill 384, sponsored by the Ohio State Medical Association in the 102nd General Assembly was signed into law by Governor C. William O'Neill on Friday, June 14.

This measure will make it possible for Ohio non-profit research and teaching institutions to obtain unclaimed dogs from dog pounds by requesting them 24 hours in advance of the date set for their destruction, as required by law. The enactment will become effective September 13, 1957.

A full report on this measure and other medical and health legislation involved in the 102nd General Assembly will appear in the August issue of *The Journal.*

Program on Ultrasonics in Medicine Scheduled

The International Conference of Ultrasonics in Medicine, sponsored by the American Institute of Ultrasonics in Medicine, will be held at the Statler Hotel, Los Angeles, Calif., September 6-7. Details may be obtained from John H. Aldes, M. D., Secretary, 4833 Fountain Ave., Los Angeles 29, Calif. Dr. Herman Bearzy, Dayton, is a member of the Institute's Executive Board.

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A three year course fulfilling all the requirements of the American Board of Dermatology and Syphilology. Attendance at departmental and general conferences.

OBSTETRICS and GYNECOLOGY

A two months full time course. In Obstetrics: lectures; prenatal clinics; attending normal and operative deliveries; detailed instruction in operative obstetrics (manikin). X-ray diagnosis in obstetrics and gynecology. Care of the newborn. In Gynecology: lectures; touch clinics; witnessing operations; examination of patients pre-operatively; follow-up in wards post-operatively. Obstetrical and gynecological pathology. Culdoscopy. Studies in Sterility. Anesthesiology. Attendance at conferences in obstetrics and gynecology. Operative gynecology on the cadaver.

PROCTOLOGY AND GASTROENTEROLOGY

A combined course comprising attendance at clinics and lectures; instruction in examination, diagnosis and treatment; pathology, radiology, anatomy, operative proctology on the cadaver, anesthesiology, witnessing of operations, examination of patients preoperatively and postoperatively in the wards and clinics; attendance at departmental and general conferences.

PRACTICAL ELECTROCARDIOGRAPHY

A two weeks part time elementary course for the practitioner based upon an understanding of electrophysiologic principles. Standard, unipolar and precordial electrocardiography of the normal heart. Bundle branch block, ventricular hypertrophy, and myocardial infarction considered from clinical as well as electrocardiographic viewpoints. Diagnosis of arrhythmias of clinical significance will be emphasized. Attendance at and participation in, sessions of actual reading of routine hospital electrocardiograms.

FOR INFORMATION ABOUT THESE AND OTHER COURSES ADDRESS—
THE DEAN, 345 West 50th Street, New York 19, N. Y.

Medical Fee Schedule Slashed . . .

Division of Aid for Aged Forced to Cut Fees and Allowances in Health Program Because of Reduction in Biennial Appropriation

BECAUSE the Ohio General Assembly which just adjourned, failed to appropriate funds in an amount sufficient to meet the estimated costs of the Health Care Program of the State Division of Aid for the Aged during the biennium starting July 1, 1957, revisions in the policies governing the health care program and drastic cuts in the schedules of fees and allowances for medical, hospital and all other services and materials involved in health care have been ordered by the director of the Department of Public Welfare, effective July 1.

SUMMARY OF CHANGES IN SCHEDULE

Here is a summary of the way the medical fee schedule will appear on and after July 1:

Fees Unchanged:

Treatment at home (day)	$ 4.00
Treatment (emergency) at home, office or hospital between 10 P. M. and 7 A. M.	$ 7.00

Fees Changed:

Treatment at office (day) reduced to	$ 2.50
Treatment at hospital (day) reduced to	$ 2.00
Treatment in nursing home, first patient	$ 4.00
Each additional patient seen at same visit	$ 2.00

Mileage: Payment for mileage abolished.

Items in fee schedule previously listed from $1.00 to $2.00 reduced to $1.00.

All items in previous fee schedule in excess of $2.00 reduced by one-third and adjusted to the nearest dollar.

CHANGES IN PROCEDURES

Policy changes:

Limitation on Visits: Payment will be made for not more than two (2) visits for chronic cases and ten (10) visits for acute cases, per patient, in any thirty (30) day period.

Prior Authorization for Elective Surgery: Only emergency surgery will be paid for by the Division of Aid for the Aged without authorization. The claim for payment will be accepted only if the surgeon has attached to his bill a signed statement that it was necessary to perform the surgery for the immediate preservation of the recipient's life, or because of a fracture or similar emergency. Payment for elective surgery will be considered in exceptional situations by the Medical Director. Authorization for payment for elective surgery will not be granted until application is received stating in full the exceptional circumstances believed to warrant approval.

The medical and surgical fee schedule has been revised to incorporate the changes listed above. It will be published and copies will be mailed as soon as possible by the Division to physicians who have been rendering services to recipients. Copies will be supplied by the Division to any physician on request.

REASONS CITED BY DIVISION

Starting July 1, 1956, the Division of Aid for the Aged medical-health program began functioning without the $200 limitation per case per year, which limit was removed by the Legislature in 1955, effective July 1, 1956.

Officials of the Division, estimating their needs on the basis of the rate of expenditure without any limitation during the fiscal year ending June 30, 1957, asked the recent Legislature for approximately $29 million to spend on health care during the biennium 1957-58 and 1958-59.

This item was cut back to $18 million. The differential, amounting to $11 million, represents the dollar amount of curtailment thought by the Division to be necessary during the next two years of operation.

ALL CATEGORIES CUT

Percentagewise, according to Division spokesmen, the $18 million appropriated would meet only about 60 per cent of the agency's obligations if operations were to continue on the basis of the past fiscal year. Therefore, the Division stated it found it necessary to limit health care payments in all categories of health care for the biennium. These include hospitalization, nursing care, dental and optometrical services, and drugs and supplies, in addition to medical services.

Obstetrics and Gynecology

Applications for certification by the American Board of Obstetrics and Gynecology, new and reopened, Part I, and requests for re-examination Part II are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline date for receipt of applications is September 1, 1957. No applications can be accepted after that date. Details may be obtained by writing to the Secretary's office, Robert L. Faulkner, M. D., 2105 Adelbert Road, Cleveland 6, Ohio.



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Youngsters really go for the taste-true orange flavor of ACHROMYCIN V SYRUP. But this new syrup offers more than "lip-service" to your junior patients. It provides the new benefits of RAPID-ACTING, phosphate-buffered ACHROMYCIN V—

- accelerated absorption in the gastrointestinal tract
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ACHROMYCIN V SYRUP: aqueous, ready-to-use, freely miscible. 125 mg. tetracycline per 5 cc. teaspoonful phosphate-buffered.

DOSAGE: 6-7 mg. per lb. of body weight per day.

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LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

NO NEED TO PAY BONUS FOR BIRTH CERTIFICATE

Physicians should remind their patients that they can obtain a certified birth certificate from the State Bureau of Vital Statistics for 50 cents ($1 effective August 20).

This reminder is prompted by a scheme in Ohio whereby parents of new babies are offered birth certificates for $2. The Columbus Better Business Bureau, Inc., has listed the offer, by Birth Certificate Service, 81 E. State Street, Columbus, as a means of promoting the sale of photographs and an album.

The Bureau of Vital Statistics reports that for an individual or firm to obtain birth certificates for a fee of $2 each is in itself not a violation of any Ohio's statutes. However, anyone can readily obtain such a certificate by writing directly to the Bureau and enclosing the legal fee. There is no necessity for involvement of a third party. The 50-cent fee the Bureau may charge for each certificate was increased to $1, effective August 20, by the 102nd General Assembly.

MAHONING COUNTY SOCIETY HANDLES PR PROBLEM WELL

Increases in minimum fee schedules create certain public relations problems that are not easily solved. It is physically impossible for a medical society to explain individually to each and every layman in the community just why fees are increased.

Such was the problem faced recently by the Mahoning County Medical Society. Taking the philosophy of the slogan, "I invite you to discuss frankly with me any question regarding my services or fees—the best medical care is based on a friendly mutual understanding between doctor and patient," members of the Mahoning group acted accordingly.

They saw that the new minimal fee schedule for office and house calls approved by the society was fully publicized by press, radio and television facilities. This publication was in accordance with an established policy of the Mahoning County Medical Society. It was done from a viewpoint of explaining, and not from a viewpoint of apology.

A recent nationwide survey indicated that patients worry about not knowing what fees they will be charged and worry not at all or very little when fully informed as to fees.

As Dr. S. W. Ondash, Mahoning County Medical Society president, summed it up, "After all, as physicians striving to maintain good relations with our public, we must be as ready to point out the cost of medical care in terms of maintaining good health as we are to maintain good health on an 'around the clock' basis in our community."

In our opinion, this medical group used a logical and affirmative approach in solving a public relations problem.

'WHEN YOU BEGIN PRACTICE' LECTURES APPRECIATED

"Thank you for an excellent program which we hope will become a permanent part of the undergraduate curriculum at WRU."

Such was the concluding statement in a letter from the Western Reserve University School of Medicine's Junior Class to the Ohio State Medical Association as a means of thanking OSMA for presenting for those students a series of special talks on the medical, legal and economic aspects they will face when they begin practice.

Held regularly at Ohio State University and the University of Cincinnati, 1957, marked the first series at WRU. While the lectures, sponsored by the Committee on Rural Health, are primarily designed to encourage these future physicians to consider practice in small towns and rural areas, they are of value to any student who plans to enter the medical profession.

The students wrote OSMA that "the Class of 1958 of the Western Reserve University School of Medicine would like to express appreciation for the series of lectures presented by the OSMA. Without exception, each speaker presented a valuable discussion of problems and situations which we will all be encountering in the not-too-distant future. Many points were brought out which had not been considered by most of us.

"Such discussions as these are certainly appreciated by students and serve to stimulate thought along lines of practicalities involved in medical practice. The banquet was a perfect culmination of the program and was thoroughly enjoyed by all who were able to attend."

In our opinion, the letter illustrates (1) that the busy physician who finds time to participate in activities of his medical organizations, whether it be on the local society level or the state level, is making a definite contribution to the medical profession; (2) although some efforts may go unmentioned, they nevertheless are appreciated; (3) close contact between medical organization and our medical students pays dividends.

Similar letters of thanks were received in previous years from the students at Ohio State and Cincinnati, indicating that the lectures are not only desirable but extremely valuable.

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JOHN E. ALLEN, M. D.
Medical Director

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

National Science Foundation survey shows medical schools in U. S. spend about as much for research as for teaching purposes. Also, between 1941 and 1954 Federal aid to medical school research increased from less than $1 to $22,800,000. The survey further showed that non-Federal research support increased at about the same rate, until the 1956-57 fiscal year when the U. S. allocation was doubled.

* * *

VA has tightened policy on hospitalization of non-service connected cases where veteran is covered by workmen's compensation. Action follows AMA talks with VA and other Federal agencies. Once it is established the veteran is covered by such compensation, he will be asked to review his oath of "inability to pay" for private treatment and to agree to a transfer to a non-VA hospital. If veteran refuses, he will be informed this information will be transmitted to VA headquarters in Washington. VA can refer such cases to Justice Department for possible prosecution.

* * *

Ten million persons now are getting Social Security payments at the rate of $540 million a month. During 1957, benefits under Old Age and Survivors Insurance will total some $7 billion, plus an estimated $75 million for the new disability payments under 50 program. First disability checks are to start in August. Overall SS coverage totals 73 million persons.

* * *

National Library of Medicine plans are being started by architects and library officials are hoping to get first construction money, $9 million, next year, but must surmount a presidential ban on new construction by Federal agencies.

* * *

AFL-CIO executive council has allocated an undisclosed amount of money to finance legal counsel, technical aid and publicity in behalf of labor-sponsored medical service plans, demonstrating labor's willingness to give money as well as moral support to direct medical service plans.

* * *

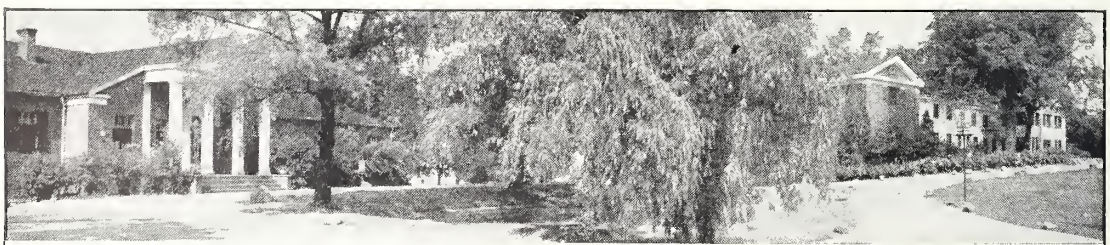
National Cancer Institute Director John R. Heller, M. D., is optimistic that the cytologic test method—already proved successful in early diagnosis of uterine cancer—may soon be found applicable to prostate, urinary, gastrointestinal and lung cancer. He said Columbus, Ohio, will be center for investigation dealing with malignancies of the large intestine.

* * *

Dr. Frank Berry, assistant defense secretary, has reported "sharp" decrease in number of resignations from medical branches of the armed forces, and attributes this to the carcer incentive act whereby doctors serving beyond two years get additional pay and additional credit toward promotions and retirement. He said there are enough physicians now commissioned or committed to service to take care of military needs for the next fiscal year without drafting any doctors.

* * *

Dr. H. L. Friedell at Western Reserve University has been awarded by the Atomic Energy Commission $252,500 contract to suport radiobiology studies. Award was one of 29 contracts totaling about $750,000.



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Each INCREMIN Tablet
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l-Lysine	300 mg.	Pyridoxine (B_6)	5 mg.
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In Memoriam . . .

William J. Dalton, M. D., Cincinnati; University of Cincinnati College of Medicine, 1943; aged 38; died May 4; member of the Ohio State Medical Association and the American Medical Association. Dr. Dalton practiced in Cincinnati following completion of his internship at Christ Hospital. He was both a physician and a dentist. A veteran of World War II, he served with the Army overseas. Dr. Dalton belonged to several professional organizations both in medicine and dentistry. Survivors include his widow, a son, a daughter, his father and a sister.

Charles R. Campbell, M. D., Cincinnati; Eclectic Medical College, Cincinnati, 1906; aged 81; died May 18. Dr. Campbell practiced medicine for about 24 years, later devoting most of his time to public office. He was elected a member of the first Hamilton County Board of Health, giving that up to become a member of the Hamilton County Board of Commissioners, a post he held for 20 years. He was former president of the state and national Eclectic Medical Associations; was a member of several Masonic bodies, the Order of Moose, Junior Order of Mechanics and the United Brethren Church. Surviving are his widow and a sister.

Walter R. de Forest, M. D., Hamilton; Columbia University College of Physicians and Surgeons, 1937; aged 47; died May 18; member of the Ohio State Medical Association and the American Medical Association, and diplomate of the American Board of Preventive Medicine. Dr. deForest was health commissioner for Hamilton, where he moved from Morgantown, W. Va., early this year. A former Army career man, Dr. deForest had been in public health work since the war. He was a 32nd Degree Mason, a member of the Rotary Club and active in Boy Scout work. Survivors include his widow, a daughter and two sons.

August B. Gudenkauf, M. D., Sidney; Ohio Medical University, Columbus, 1905; aged 86; died April 30; former member of the Ohio State Medical Association. Dr. Gudenkauf's family came from Germany when he was a child and settled in Shelby County where he received his early education. Upon completion of his medical training, he returned to that county and set up practice in Sidney. He retired in 1945 and later received the 50-Year Award of the Ohio State Medical Association. He was a member of the Catholic Church and the Knights of Columbus. Survivors include his widow, three daughters, a son and a brother, Dr. Henry Gudenkauf, of Minster.

Walter H. Hartung, Sr., M. D., Toledo; Toledo Medical College, 1912; aged 69; died June 1; former member of the Ohio State Medical Association. A native of Toledo, Dr. Hartung began practice there upon completion of his education, but devoted most of his professional career to public health work. He was director of the Ohio Department of Health from 1934 to 1939, and had been Toledo's health commissioner since 1943. He had previously served as county coroner, and during World War I served with the Army Medical Corps. Affiliations included memberships in the Catholic Church, the Knights of Columbus, the Elks Lodge and the Ohio State Public Health Association. Survivors include his widow, two daughters and a son, Dr. Walter Hartung, Jr., also of Toledo; also a brother.

Robert Lewis Lawwill, M. D., Seaman; Eclectic Medical College, Cincinnati, 1922; aged 60; died May 20; member of the Ohio State Medical Association and the American Medical Association. Dr. Lawwill practiced for a short time in Omar, West Virginia, and in Manchester, before he moved to Seaman in 1925. He had been health commissioner for Adams County since 1941 and at one time was commissioner for both Adams County and Brown County. He also was administrator of the Adams County Hospital. He was a member of the Methodist Church, several Masonic bodies and the Lions Club. Surviving are his widow, two sons and a brother.

Charles S. McGeorge, M. D., Negley; University of Pittsburgh School of Medicine, 1900; aged 81; died May 4; former member of the Medical Society of the State of Pennsylvania. Dr. McGeorge was a practicing physician for many years in Ambridge, Pa., and was associated with the Sewickley Valley Hospital of that area, before he retired in 1949 and moved to the Ohio town. Two sons practice in Ambridge, Drs. Francis R. and Paul E. McGeorge. Also surviving are his widow, two daughters and a sister.

William C. D. Millhoff, M. D., Clayton, New Mexico; Harvard Medical School, 1918; aged 64; died May 28. Dr. Millhoff practiced for 19 years in Cleveland before he moved to New Mexico in 1936. Survivors include his widow, a daughter, a son, a brother and two sisters.

Joseph S. Podesta, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1901; aged 80; died April 25; member of the Ohio State Medical Association and the American Medical Association to the current year. A native of Cincinnati, Dr. Podesta practiced in that city for 56 years and had been honored with the 50-Year Award of the Ohio State Medical Association. An active supporter of work among the American-Italians of the area, Dr. Podesta had been conferred the title of Cavaliere and Knight of the Crown by King Victor Emanuel of Italy. He was a member of the Elks Lodge, Knights of Columbus and the

Catholic Church. His son, Dr. Joseph J. Podesta, also of Cincinnati, survives.

Frank A. Poole, M. D., Saginaw, Mich.; Medical College of Ohio, Cincinnati, 1879; aged 85; died April 25; member of the State Medical Society of Michigan. A native of DeGraff, Dr. Poole practiced there and in Bellefontaine before he moved out of the state. He was public health director in Saginaw for 30 years. Survivors include his widow, and a sister.

Charles R. Rein, M. D., New York City; University of Michigan Medical School, 1928; aged 52; died May 15. A native of Toledo and former resident at Mt. Sinai Hospital, Cleveland, Dr. Rein was an internationally known dermatologist. His widow, two sons and three sisters survive.

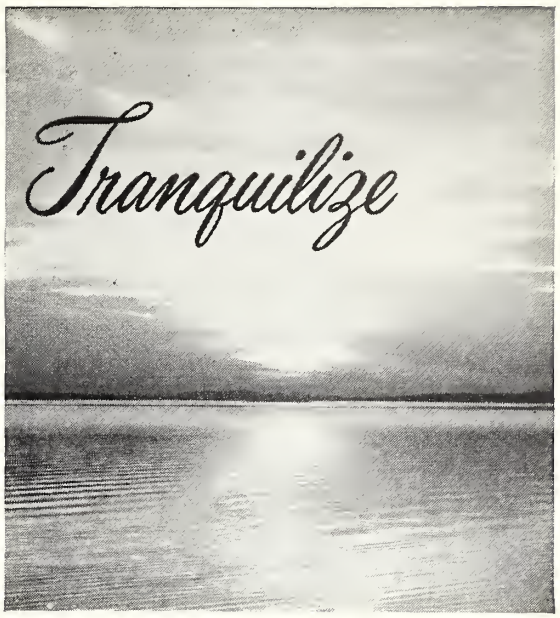
Roy Wesley Scott, M. D., Cleveland; Western Reserve University School of Medicine, 1913; aged 69; died May 26; member of the Ohio State Medical Association, American Medical Association, Central Society for Clinical Research, American Society for Clinical Investigation and Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine; member of numerous other professional societies. Dr. Scott's interest in the cardiovascular field went back to his internship at Lakeside and residency at City Hospital. Until 1930 his work was devoted to teaching and research, principally at City Hospital and Western Reserve, but including a year's study in Vienna. In later years he was clinical professor of medicine at Western Reserve. Dr. Scott was president of the American Heart Association, 1944-1946, and was one of the founders of the Council for High Blood Pressure. During World War II he was on the subcommittee on cardiovascular disease of the National Research Council. Surviving are his widow, a daughter and two brothers.

Charles B. Wylie, M. D., Columbus; Hering Medical College, Chicago, 1903; aged 93; died May 8; former member of the West Virginia State Medical Association. Dr. Wylie had been a practicing physician in Morgantown, W. Va., before his retirement in 1945 when he moved to Columbus. Survivors include his widow and two daughters.

Ohio State Heart Association Elects Officers for Year

Dr. John W. Martin, Cleveland, was named president-elect of the Ohio State Heart Association at its recent annual meeting in Columbus. Dr. Maurice A. Schnitker, Toledo, assumed office as president, and H. Willis Nichols, Jr., Cincinnati, was re-elected chairman of the board.

Also elected were Mrs. O. W. Haulman, Youngstown, secretary, and Charles W. McCoy, Columbus, vice-chairman and treasurer. The executive offices of the association are now located at 131 East State Street, Columbus 15.



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- Soothes the central nervous system, produces calmness without hypnosis.
- Non-toxic, non-cumulative, non-addicting, no known contraindications.
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Activities of County Societies . . .

First District

(COUNCILOR: FRANK H. MAYFIELD, M. D., CINCINNATI)

CLERMONT

"Care and Diagnosis of a Dirty Patient," was the subject discussed by Dr. Robert E. Howard, Cincinnati, before the June 19 meeting of the Clermont County Medical Society. The meeting was held at Loveland with Dr. John M. Coleman as host.

HAMILTON

The Academy of Medicine of Cincinnati had as topic for the May 21 meeting, "The International Labor Organization as a Breeding Ground of Socialized Medicine." The speaker was William L. McGrath, president of the Williamson Company, of Cincinnati, and former employer member of the ILO Governing Body.

Meetings of specialty groups during May included the following:

May 8—Cincinnati Ophthalmologic Club.

May 16—The Society of Anesthesiologists.

May 21—Cincinnati Urological Society.

May 22—Cincinnati Society of Neurology and Psychiatry.

May 22—Cincinnati Surgical Society.

May 23—Cincinnati Obstetrical and Gynecological Society.

May 27—Cincinnati Oto-Laryngological Society.

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

DARKE

Robert Freeman, Dayton, executive secretary of the Montgomery County Medical Society, gave a talk on the subject, "Public Relations of the Local Medical Society," at the May 21 meeting of the Darke County Medical Society, in Greenville.

MIAMI

The Miami County Medical Society held a late afternoon program followed by dinner at the Dettmer Hospital, Troy, on June 7. Two films were the basis of the program. The first was "The Case of the Doubting Doctor," an AMA documentary film. The second was entitled, "Culdocentesis," and was a Lederle film on this technique.

MONTGOMERY

The Montgomery County Medical Society on May 3 approved a medical-legal code drawn up after two years of study by committees of the Medical Society and the Dayton Bar Association. A feature of the meeting was a talk by Dr. Thomas H. Alphin, director of the Washington Office of the American Medical Association. He discussed national legislation as it shaped up in Congress at the time. The business meeting followed dinner at the Van Cleve Hotel.

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

MERCER

The following report of a meeting on May 9 is quoted from the *Celina Standard*:

The first joint meeting of the Mercer County Bar Association and the Mercer County Medical Association was held last night in Bay View Lodge. The enthusiasm and understanding of mutual problems gained, make it seem certain that it will develop into an annual affair.

Some 60 doctors, lawyers and their wives were present at the event planned by officers of the two groups, an entertainment committee consisting of Judge R. A. Younger, Don W. Montgomery, Walter R. Bernard, Dr. Robert F. Brashear, Dr. Louis J. Finkelmeier, Dr. George H. McIlroy, and planned by Carleton C. Reiser.

Mercer County Common Pleas Judge Paul P. Dull asked the blessing before the meal.

Reiser, Bar Association president, welcomed the group and was followed by Judge Younger who introduced his fellow judges of the Third Appellate District, Judge J. Thomas Guernsey and Judge George S. Middleton.

Dr. Robert Fell, Medical Association president, introduced Dr. James Jarvis, of Van Wert. Reiser read a letter of apology at being unable to attend from District Judge Frank L. Klobe.

A film, "The Medical Witness," vividly portraying the necessity of preparation for court appearances on the part of both lawyers and doctors, was a highlight of the evening, as was the reading of the Lawyer's Oath of Admission and the Doctor's Oath of Hippocrates.

Also attending were administrators of the three county hospitals, Gibbons, Our Lady of Mercy, and Otis.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

Five resident physicians of the Youngstown Hospital Association and St. Elizabeth Hospital spoke at a Mahoning County Medical Society dinner meeting on May 21 at the Elks Club.

The five physicians told of the work they have been doing and outlined some of the results. Dr. Stephen W. Ondash, president, presided.

Dr. Carol Craig, senior medical resident, Youngstown Hospital, spoke on her experience with the use of orinase.

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surgical resident and pathology resident of the Youngstown Hospital, jointly presented a paper on carcinoid.

Dr. Humberto Gonzales, surgical resident of St. Elizabeth Hospital, presented a case report of a patient having the appearance of an acute surgical condition of the abdomen, but who was later found to be suffering from parasite infection.

Dr. Rudolph Schuldes, chief resident of obstetrics and gynecology at St. Elizabeth Hospital, presented a case of pregnancy occurring outside the uterus.—Excerpted from *Youngstown Vindicator*.

Members of the medical profession participated in a program of the Mahoning Valley Chiropody Society at which the late Dr. William M. Skipp was honored for his leadership in organizing the Allied Professions Committee. A plaque was presented to Mrs. William Skipp. Dr. C. A. Gustafson, Councilor for the Sixth District, and Dr. Stephen W. Ondash, president of the Mahoning County Medical Society, participated in the program. Representatives of the local organizations of pharmacists and dentists also were present.

PORTAGE

Following is a summary of activities of the Portage County Medical Society for the early part of this year:

In January the Society met and members unanimously approved a motion that the Portage County Medical Society is in agreement with the action taken by the Ohio State Medical Association in relation to the Medicare Program. The Society also recommended that all the physicians in Portage County follow the recommendations of the American Heart Association for the treatment of streptococcal infections which were referred to them by the Portage County Health Association nurse in her Strep Throat Culture School Child Program.

At the March meeting also held at the Portage County Hospital, a film showing the effective use of Flexin was viewed. Three members were elected to the Board of Censors. They were Dr. Elwell, of Garrettsville; Dr. Dumm, of Kent; and Dr. Silbiger, of Atwater. President Roy reported that the County Commissioners had met and appointed a non-M. D. to the Hospital Board against the wishes of the County Society. The Society voted to raise its annual dues from $5 to $25.

The April meeting was held as a luncheon at the Twin Lakes Country Club on April 17. Dr. Julius Hoffman, assistant professor of psychiatry at Ohio State University in Columbus, spoke on the "Armamentarium of the Psychiatrist."

On May 21 at the Portage County Hospital a business meeting was held. The Society unanimously voted to pay one dollar per member to the Sixth Councilor District treasury to help defray the expenses of the Postgraduate Day to be held in Kent in October. Two new members were accepted. They are Dr. Tony Adamle, of Kent, and Dr. John Chapin, of Twinsburg. Following refreshments the members viewed a film entitled "Modern Concepts of Epilepsy."

TRUMBULL

Dr. Allan C. Barnes, professor of obstetrics and gynecology at Western Reserve University, Cleveland, was guest speaker at the May 22 meeting of the Trumbull County Medical Society. The annual meeting held in conjunction with the Woman's Auxiliary was held at the Trumbull Country Club, Warren.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

A joint meeting of the Belmont County Medical Society and the Auxiliary was held at the Belmont Hills Country Club on June 20. On the program for that occasion was Dr. Louis J. Karnosh, of the Department of Psychiatry, Cleveland Clinic, who spoke on the subject, "Psychiatric Problems."

TUSCARAWAS

A number of Tuscarawas County law enforcement officers were guests of the Tuscarawas County Medical Society on May 9 at Union Hospital, where a film on narcotics issued by the federal government was shown. Dr. Donald W. Mastin, of Dover, had charge of the program.

The Society also approved an application from the Medical Office Assistants' Association, of Tuscarawas, to affiliate with the state organization.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

A panel discussion on the interrelationship between General Practitioners and Specialists constituted the program for the June 10 meeting of the Scioto County Medical Society. The meeting was held in the Recreation Hall of the General Hospital, Portsmouth, followed by a buffet supper. Program was arranged by Dr. B. U. Howland.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

The Columbus Academy of Medicine met at the Deshler-Hilton Hotel on June 13 for a program and dinner. The general theme was "Common Problems of the Medical and Pharmaceutical Professions."

Subjects and speakers were as follows:

"Current Use of Antibiotics," Dr. Eugene H. Swanzey, Lederle Medical Research Section of the American Cyanamid Company, Chicago.

"Antihypertensive Drugs," Dr. Richard A.

(Continued on Page 860)

AMATE

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• "The results in several people who were previously on belladonna-phenobarbital preparations are particularly interesting. Several people volunteered that they felt a great deal better on the present medication and noted less of the loginess associated with barbiturate administration."[6]

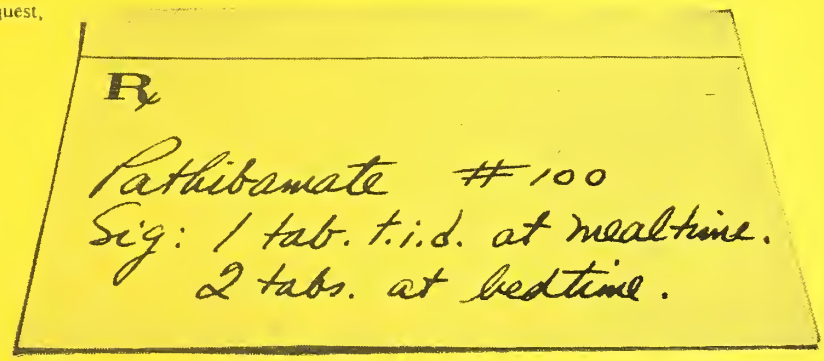
• PATHIBAMATE..."will favorably influence a majority of subjects suffering from various forms of gastrointestinal neurosis in which spasmodic manifestations and nervous tension are major clinical symptoms."[7]

• "In the patients with functional disturbances of the colon with a high emotional overlay, this has been to date a most effective drug."[5]

References: 1. Borrus, J. C.: *M. Clin. North America,* In press, 1957. 2. Gillette, H. E.: *Internat. Rec. Med. & G. P. Clin.* 169:453, 1956. 3. Pennington, V. M.: *J.A.M.A.,* In press, 1957. 4. Cayer, D.: Prolonged Anticholinergic Therapy of Duodenal Ulcer. Am. J. Dig. Dis. 1:301-309 (July) 1956. 5. McGlone, F. B.: Personal Communication to Lederle Laboratories. 6. Texter, E. C., Jr.: Personal Communication to Lederle Laboratories. 7. Bauer, H. G. and McGavack, T. H.: Personal Communication to Lederle Laboratories.

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Dunsmore, chief of the Hypertension Clinic at Philadelphia General Hospital.

"Tranquilizers," Dr. J. H. Walton, editor of the *Clinical Symposia* for Ciba Pharmaceutical House.

"Doctors, Drugs and News," Dr. George E. Farrer, Jr., medical director at Wyeth Laboratories and associate professor of medicine at Temple University.

"Modern Use of Hormones," Dr. J. E. Gaijewski, from Parke, Davis & Company.

After dinner a panel discussion was held on the subject "Mutual Problems of Physicians and Pharmacists," with the following persons participating: George W. Kauffman, the Kauffman-Lattimer Company, Columbus; Ray Walter, The Tremont Pharmacy and president-elect of the Central Ohio Academy of Pharmacy; Ralph A. Sears, wholesale pharmacist; John Hochreiter, Upjohn Pharmaceutical Company; Sister Mary Florentine, C. S. C., chief pharmacist at Mt. Carmel Hospital and president of the Ohio Society of Hospital Pharmacists; Lloyd M. Parks, Ph. D., dean of the College of Pharmacy at Ohio State University; Dr. Oscar L. Coddington, representing the dispensing physicians; Dr. George Farrer, representing the manufacturing pharmaceutical industry; Dr. Robert H. Schoene and Dr. Wiley L. Forman, representing the non-dispensing physicians, and Joseph R. Sabino, practicing pharmacists.

New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since May 1, 1957. The list shows the County in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

BELMONT COUNTY

Matt L. Kirkland, Jr., St. Clairsville
Thomas L. Ring, Bellaire

CUYAHOGA COUNTY

Harold L. Brodell, Cleveland
William F. Collins, Jr., Cleveland
John C. Elder, Cleveland
William H. Gillard, Cleveland
Maria Henke, Cleveland
Eugene E. Mihalyka, Cleveland
Chester L. Plotkin, Cleveland
Erma A. Smith, Cleveland

FRANKLIN COUNTY

Friedrich K. Urschler, Columbus

HAMILTON COUNTY

Carl A. Liebig, Cincinnati
Samuel J. Newman, Cincinnati
Richard B. Salzer, Cincinnati
Albert W. Schreiner, Cincinnati
Klaus L. Stemmer, Cincinnati
John T. Toppen, Cincinnati

LAKE COUNTY

Henry Brazaitis, Willoughby
Joseph W. Koelliker, Jr., Willoughby
John C. McClelland, Painesville

MAHONING COUNTY

Stanley L. Grosshandler, Youngstown

MONTGOMERY COUNTY

Harold G. Kelso, Dayton

PORTAGE COUNTY

Tony Adamle, Kent
John L. Chapin, Twinsburg

SENECA COUNTY

E. Crede Hiestand, Old Fort
H. Robert Niemann, Tiffin
Robert R. Schwalenberg, Jr., Tiffin
Thomas W. Watkins, Tiffin

SUMMIT COUNTY

Vladas Adams, Akron
Archibald J. Beatty, Akron
George H. Donnelly, Akron

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Tel. Redwood 1-0657
CLEVELAND Office: J. R. Ticknor and R. G. Woehr, Rep.
1836 Euclid Ave., Prospect 1-5454
COLUMBUS Office: John E. Hansel, Rep.
3048 Woodbine Place,
Tel. AMherst 2-6200

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HOSPITAL SUPPLIES

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Cleveland Facilities Not Adequate For June AMA Meeting

An interesting sidelight on the recent AMA meeting in New York City is the article which appeared on June 11 in the *Cleveland Press*, based on a report by Don Dunham, medical writer for *The Press*, revealing the space and hotel demands of the annual session of the AMA and why Cleveland can't meet the challenge at this time. The article—actually an editorial—published by *The Press* read as follows:

"In the world of conventions, the annual meeting of the American Medical Association is really the cream.

"It's one of the biggest, attracting some 20,000 doctor-delegates and 25,000 guests.

"The convention has prestige stamped all over it.

"And with the single exception of the political conventions every four years, it makes the most headlines.

"The convention is the platform from which medical men sum up all the hopeful progress of the preceding year. The city where it's held is a familiar date line all over the world during the week the gathering is in progress.

"But Cleveland, long one of the front-runners among convention cities — can't attract this gathering.

"Why?

"Not because the association doesn't want to meet here.

"Quite the contrary, Cleveland is a great center of medical research. Doctors would like very much to come here.

"Rather, it's simply because Cleveland doesn't have enough exhibition space, or enough hotel rooms.

"This year's convention just ended in the new Coliseum in New York City.

"Here's a report from Don Dunham, who covered the meetings for *The Press*, on what the doctors found:

" 'The Coliseum was a revelation to all of the doctors and their guests.

" 'The entire hall is air conditioned. It is well designed in a modern manner. It has roomy and swift elevators as well as escalators for easy mobility from floor to floor and meeting hall to meeting hall.

" 'It has ample space for what were the finest scientific and commercial exhibits the AMA ever had. They were not jammed on top of each other. The aisles between were wide.

" 'It is easily reached and virtually all of one side of the building opens into a series of giant doorways through which thousands of visitors can pass without wait or jamming.'

"That's the kind of competition Cleveland is meeting in the battle to keep its convention business.

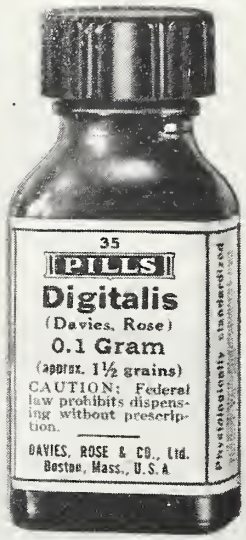
"And the plain facts are that Cleveland is in serious danger of losing the battle.

"It will continue to be in trouble, too, until the city's financial and civic leadership finally stops talking and starts acting on the new hotel problem.

"And until City Hall people stop talking and start acting on more exhibition space."

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Activities of Woman's Auxiliary . . .

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(See Page 745 for roster of officers.)

COLUMBIANA

In recognition of "Doctor's Day" sponsored by the Woman's Auxiliary to the Columbiana County Medical Society local physicians and dentists were honored at a "coffee hour" on May 8 at City Hospital, East Liverpool. A "hard times" dinner was featured in the evening at the Country Club to climax the event with Dr. Roy Costello as Master of Ceremonies. He introduced Dr. Fraser Jackson and Dr. William McCutcheon who spoke briefly. Davis Ellis of Pittsburgh, president of the Hypnosis Society was the guest speaker.

Mrs. William J. Horger, president of the Auxiliary and her committee, Mrs. H. T. Banfield, Mrs. W. S. Banfield, Mrs. Alex Fisher, Mrs. Charles Gerace and Mrs. K. W. Turner with Dr. Kudley H. Beaumont of Wellsville were in charge of the program and arrangements for the observance.

Mrs. William J. Horger and Mrs. Virgil Hart were delegates to the State Convention and were in charge of the "In Memoriam" service.

FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Society held a luncheon meeting in Hotel Lancaster, May 20. The president, Mrs. C. R. Reed, conducted the business meeting. A brief review of the main projects was given. Under the leadership of Mrs. G. S. Rodabaugh and Mrs. George LeSar, the Future Nurses' Club of Lancaster High School enlarged its programs to include other health careers—laboratory technician, X-Ray technician, dietition, and physical-therapy. Eleven girls are going into the nursing profession this year. Mrs. S. C. Sneeringer, chairman of Mental Health and Mrs. F. W. James, chairman of Safety, reported on their activities. A contribution of $25 was made by the Auxiliary to the American Medical Education Foundation and also $25 to the State Nurses' Education Fund. Mrs. Rodabaugh and Mrs. James gave the highlights of the recent State Medical Auxiliary meeting in Columbus.

Mrs. Harold K. Mouser of Coral Gables, Florida, and a past State President, presently visiting in Marion and Columbus, installed the new officers. Mrs. Mouser had organized the Auxiliary 10 years ago during her term as State President. The new officers installed are: Mrs. George LeSar, President; Mrs. George F. Jones, President-Elect; Mrs. Charles Clark, Vice-President; Mrs. Kenneth Gaines, Secretary; and Mrs. W. J. Boswell, Treasurer. Mrs. LeSar then announced her committee chairmen for the coming year.

Hostesses for the day were Mrs. W. A. Welch, Mrs. Jones and Mrs. Kenneth Taylor.

HAMILTON

The final meeting of the Woman's Auxiliary to the Hamilton County Medical Society was held May 21 at the Kenwood Country Club. A luncheon was served followed by the announcement and installation of new officers and an informal entertainment.

Mrs. N. J. Giannestras was hospitality chairman of the day and was assisted by Mrs. Robert E. Slemmer. Mrs. E. H. Schweitzer was in charge of the decorations.

Following the luncheon a brief business meeting was conducted by the President, Mrs. Calvin F. Warner.

Mrs. William Lippert, chairman of tellers announced the newly elected officers. Installation ceremonies followed immediately and were conducted by Mrs. H. J. Brinker. Mrs. Gaston Hannah, President-Elect, received the official gavel from Mrs. Warner, retiring president. Mrs. Warner was presented with a gold pin as an award of merit for her year's service to the Auxiliary. Mrs. Gaston Hannah gave a report on the Ohio State Convention.

Mrs. Harry Hines and Mrs. Harry Fry, co-chairmen of the program, presented slides from

(Continued on Page 864)



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the Medical Centennial and an original skit, leaving most of the time for socializing as part of the day's entertainment.

A joint board meeting was held May 28 at the Hyde Park Country Club with Mrs. Warner presiding.

JEFFERSON

Mrs. William Mikita was elected president of the Woman's Auxiliary to the Jefferson County Medical Society on May 22 at a luncheon meeting in the home of Mrs. J. L. Thompson of Smithfield. The retiring president is Mrs. John Mantica.

Also elected for the coming year were Mrs. Earl Rosenblum, president-elect; Mrs. Ernest Perri, vice-president; Mrs. D. R. Cahill, corresponding secretary; Mrs. John Smarrella, recording secretary, and Mrs. Jack Cohen, treasurer. A unanimous vote of appreciation was given to the retiring officers.

Mrs. Mantica and Mrs. Carl Goll reported on the State Convention held in Columbus. Mrs. Goll was elected Director of District Seven.

Activities of the Future Nurses Clubs were reported and applicants were considered for scholarship loans.

Guests at the luncheon were Mrs. W. Everhard of New Philadelphia, past District Director, and Mrs. W. Miller of Dennison. Meetings will resume in the fall.

MAHONING

The annual dinner of the Woman's Auxiliary to the Mahoning County Medical Society was held on May 8 at the Youngstown Country Club with 60 members in attendance.

Officers were installed and committee chairmen announced. Taking office as President was Mrs. Cary S. Peabody, who succeeds Mrs. Paul J. Mahar. Mrs. Earl Young is President-Elect. Mrs. Milton Kendall, vice-president; Mrs. George Altman, corresponding secretary; Mrs. William Geordan, treasurer, and Mrs. Paul Ruth, recording secretary.

Chairmen of standing committees announced by Mrs. Peabody are: Program, Mrs. Edward S. Rizk; and Mrs. E. M. Thomas; Telephone, Mrs. Andrew Detesco; Membership, Mrs. Myron C. Hanysh; Project, Mrs. Robert L. Tornell; Finance, Mrs. Sidney Franklin; Nurses' Scholarship, Mrs. John A. Renner; Ways and Means, Mrs. Robert Brown; Yearbook, Mrs. John Stotler; Publicity, Mrs. Harold J. Reese; Public Relations, Mrs. Joseph J. Campolito; National Publications, Mrs. Lester O. Gregg; Legislative, Mrs. W. L. Agey; Parliamentarian, Mrs. Craig Wales; Historian, Mrs. Paul J. Mahar; Civil Defense, Mrs. S. B. Patton, Jr.; Television, radio and visual education, Mrs. K. C. Kunin; Credits and Awards, Mrs. B. I. Firestone; Safety, Mrs. William K. Allsop; American Medical Education Foundation, Mrs. A. E. Rappoport; and Mental Health, Mrs. Dean E. Stillson.

Mrs. Paul E. Ruth and Mrs. Robert Fisher

Cook County
Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES—SUMMER & FALL, 1957

SURGERY—Surgical Technic, two weeks, Aug. 19, Sept. 16. Surgery of Colon & Rectum, one week, Sept. 16. Basic Principles in General Surgery, two weeks, Oct. 14. Surgical Anatomy & Clinical Surgery, two weeks, Sept. 30. Treatment of Varicose Veins, Sept. 9. Fractures & Traumatic Surgery, two weeks, Oct. 21. Thoracic Surgery, one week, Oct. 7. Esophageal Surgery, one week, Sept. 30. General Surgery, two weeks, Sept. 23; one week, Oct. 28.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Sept. 16. Vaginal Approach to Pelvic Surgery, one week, Sept. 9. General & Surgical Obstetrics, two weeks, Sept. 30.

MEDICINE—General Review Course, two weeks, Sept. 23. Electrocardiography & Heart Disease, two weeks, Oct. 7. Hematology, one week, Sept. 9.

RADIOLOGY—Diagnostic X-Ray, two weeks, Sept. 16. Clinical Uses of Radioisotopes, two weeks, Oct. 7. Diagnostic X-Ray, Clinical Course, by appointment.

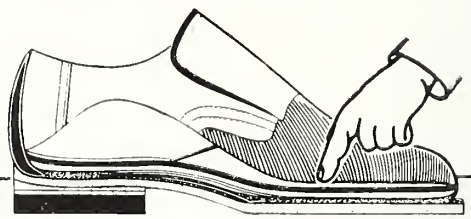
CYSTOSCOPY—Ten-Day Practical Course by appointment.

UROLOGY—Two-Week Intensive Course Oct. 7.

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were in charge of the program. Hostesses for the day were Mrs. A. E. Rappoport and Mrs. Ben S. Brown.

SCIOTO

A May breakfast at the home of Mrs. H. M. Keil highlighted the monthly meeting of the Woman's Auxiliary to the Scioto County Medical Society.

For the program, Mrs. S. L. Meltzer, a past president of the Auxiliary, installed officers for 1957-58. The new officers are: Mrs. William C. Hugenberg, President; Mrs. Armin Melior, president-elect; Mrs. Miller F. Toombs, vice-president; Mrs. Donald Appleton, secretary; Mrs. W. A. Ray, treasurer; Mrs. O. D. Tatje, historian and Mrs. C. W. Wendelken and Mrs. Carl G. Braunlin, directors.

Mrs. Wendelken, the retiring president, was presented with a president's pin by Mrs. Hugenberg.

The Auxiliary voted to make donations to the Fresh Air Camp and the exhibitors dinner for the Annual Scioto County Horse Show, sponsored by the Woman's Auxiliary of Portsmouth General Hospital.

Mrs. Keil was assisted by Mrs. P. D. Weems, Mrs. Jerome Sheets and Mrs. Harry F. Rapp, Mrs. Russell G. Ketter was a guest of the meeting.

SUMMIT

The Woman's Auxiliary to the Summit County Medical Society installed officers following a luncheon at the Woman's City Club on Tuesday, May 7.

Mrs. H. Oliver Musser, out-going president, conducted the business meeting and annual reports of committee chairmen were given.

Mrs. Christopher Colombi, Cleveland, installed the following officers: President, Mrs. R. R. Pliskin; President-Elect, Mrs. Devitt L. Gordon; Vice-President, Mrs. H. W. Allison; Treasurer, Mrs. E. L. Mollin; Recording Secretary, Mrs. A. H. Loomis and Corresponding Secretary, Mrs. L. V. Phillips.

OSMA Staff Members Participate In Public Health Session

Three members of the OSMA headquarters staff participated in the Ohio Public Health Association's annual meeting in Columbus May 28 and 29.

George H. Saville, assistant executive secretary and director of public relations, was a member of a panel which discussed "The Role of the Health Educator in Public Relations" before members of the section on health education. Hart F. Page, assistant director of public relations, was a member of the health education section's program committee and retiring secretary-treasurer of that section, while Charles W. Edgar, administrative assistant, was elected secretary-treasurer of the health education section.

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* * *

School Health Guides. Prepared by OSMA Committee on School Health, these three revised guides offer blueprint for setting up school health and emergency aid program. Available in quantity. Write OSMA, 79 E. State Street, Columbus 15, Ohio.

Correction in Report on Pulmonary Disease Course at OSU Is Noted

An error crept into the announcement in the June issue of the Course in Pulmonary Diseases at Ohio State University, September 27 and 28. Due to an error in the copy submitted to *The Journal*, it was stated that reservation should be accompanied by check for $15. The amount should have been $25. Refer to page 692, June issue, for details of the course.

New AMA Booklet

Activities and programs of the A. M. A. are described in new booklet just off the press.

Entitled "A. M. A. in Action," the booklet points out AMA services and benefits for both the medical profession and the general public. Copies have been sent to AMA officers, trustees and delegates, national opinion leaders, medical schools and pharmaceutical representatives. Also, key officials of state and county medical societies are being sent copies.

INDEX TO ADVERTISERS

American Meat Institute ... 756
Ames Company, Inc. ... 768
Appalachian Hall ... 751
Ayerst Laboratories, Inc. ... 763, 865
Barry Laboratories, Inc. ... 762
Bayer Company, The, Div. of Sterling Drug Co., Inc. ... 769
Burroughs, Wellcome & Co. (U.S.A.) Inc. ... 742
California State Personnel Board ... 867
Children's Convalescent Home and Rehabilitation Center ... 849
Ciba Pharmaceutical Products, Inc. ... 767
Columbus Pharmacal Company ... 751
Cook County Graduate School of Medicine ... 864
Corn Products Refining Co. ... 758
Davies, Rose & Co., Ltd. ... 861
Flint, Eaton, & Company ... 766
Foot-so-Port Shoe Company ... 864
Geigy Pharmaceuticals, Inc. ... 755
Harding Sanitarium ... 748
Hoffmann-LaRoche, Inc. ... Insert Between Pages 860 - 861
Lakeside Laboratories, Inc. ... 741
Lederle Laboratories ... 802-803, 847, 851; Insert Between Pages 856 & 857; 857, 858 - 859
Lewal Pharmaceutical Company ... 752
Lilly, Eli, and Company ... 772
Lloyd Brothers, Inc. ... 855
Loma Linda Food Company ... 760
Mallard, Inc. ... 853
McMillen Sanitarium ... 748
Medical Protective Company ... 860
Neil Training School ... 867
North, Emerson A., Hospital, The ... 764
New York Polyclinic Medical School ... 845
Parke, Davis & Company ... 868 and Inside Back Cover
Pfizer, Chas. & Co., Inc. ... 759, 843, 863
Pogue, Mary, School, Inc. ... 862
Riker Laboratories, Inc. ... 749
Rohins, A. H., Co., Inc. ... 765
Roerig, J. B., & Co. ... 761
Sawyer Sanatorium ... 757
Schering Corporation ... Insert between pages 756-757, and page 771
Scroggins, Clayton L., Associates (Medical-Dental Management) ... 763
Searle, G. D., & Company ... 835
Smith, Kline & French Laboratories ... 746; and Back Cover
Squihb, E. R., & Sons, Division of Olin-Mathieson Chemical Corporation ... 770
Stoneman Press ... 750
Tutag, S. J., & Company ... 750
Wallace Laboratories ... Insert between pages 768 - 769
Wendt-Bristol Company ... 860
Windsor Hospital, Inc. ... 850
Winthrop Laboratories ... 747
Year Book Publishers, The, Inc. ... 754

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

WANTED: Unmarried Female Physician to assist in busy Northern Ohio Obstetrical and Gynecologic practice. Special training welcome but not necessary. Salary first, association later. Enclose recent photo with letter. Box 911, c/o The Ohio State Medical Journal.

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MEDICAL AND DENTAL OFFICES available in a new ten-unit all airconditioned medical building. Contact A. W. Brownstone, M. D., Painesville, Ohio

OSMA School Health Guides Are Revamped

Publication of revamped, redesigned OSMA School Health Guides 1, 2 and 3 has been completed by the Committee on School Health, and the guides are being distributed on request to local school health committees, school officials and school health personnel.

The guides have been brought up to date to include the most recent medical policies and emergency procedures. Twenty thousand sets, or 60,000 copies, were printed, and have received the praise of physicians, school administrators and health educators.

WOULD LIKE TO JOIN A GROUP OR ASSOCIATE WITH A GP—to practice in Internal Medicine. Have 3 yrs. residency in Int. Medicine. I am 46 yrs. old, graduated from Vienna and have Ohio license. Box 939, c/o Ohio State Medical Journal.

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(1) Metzger, W. I., & Jenkins, C. J., Jr.: *Pediatrics* **18**:929, 1956. (2) Altemeier, W. A.: *Postgrad. Med.* **20**:319, 1956. (3) Cohen, S.: *Postgrad. Med.* **20**:483, 1956. (4) Rantz, L. A., & Rantz, H. H.: *Arch. Int. Med.* **97**:694, 1956. (5) Bennett, I. L., Jr.: *West Virginia M. J.* **53**:55, 1957. (6) Hughes, J. G., & Carroll, D. S.: *Pediatrics* **19**:184, 1957. (7) Kempe, C. H.: *California Med.* **84**:242, 1956. (8) Spink, W. W.: *Ann. New York Acad. Sc.* **65**:175, 1956. (9) Yow, E. M.: *GP* **15**:102, 1957. (10) Wise, R. I.; Cranny, C., & Spink, W. W.: *Am. J. Med.* **20**:176, 1956. (11) Royer, A.: Scientific Exhibit, 89th Ann. Conv. Canad. M. A., Quebec City, Quebec, June 11-15, 1956.

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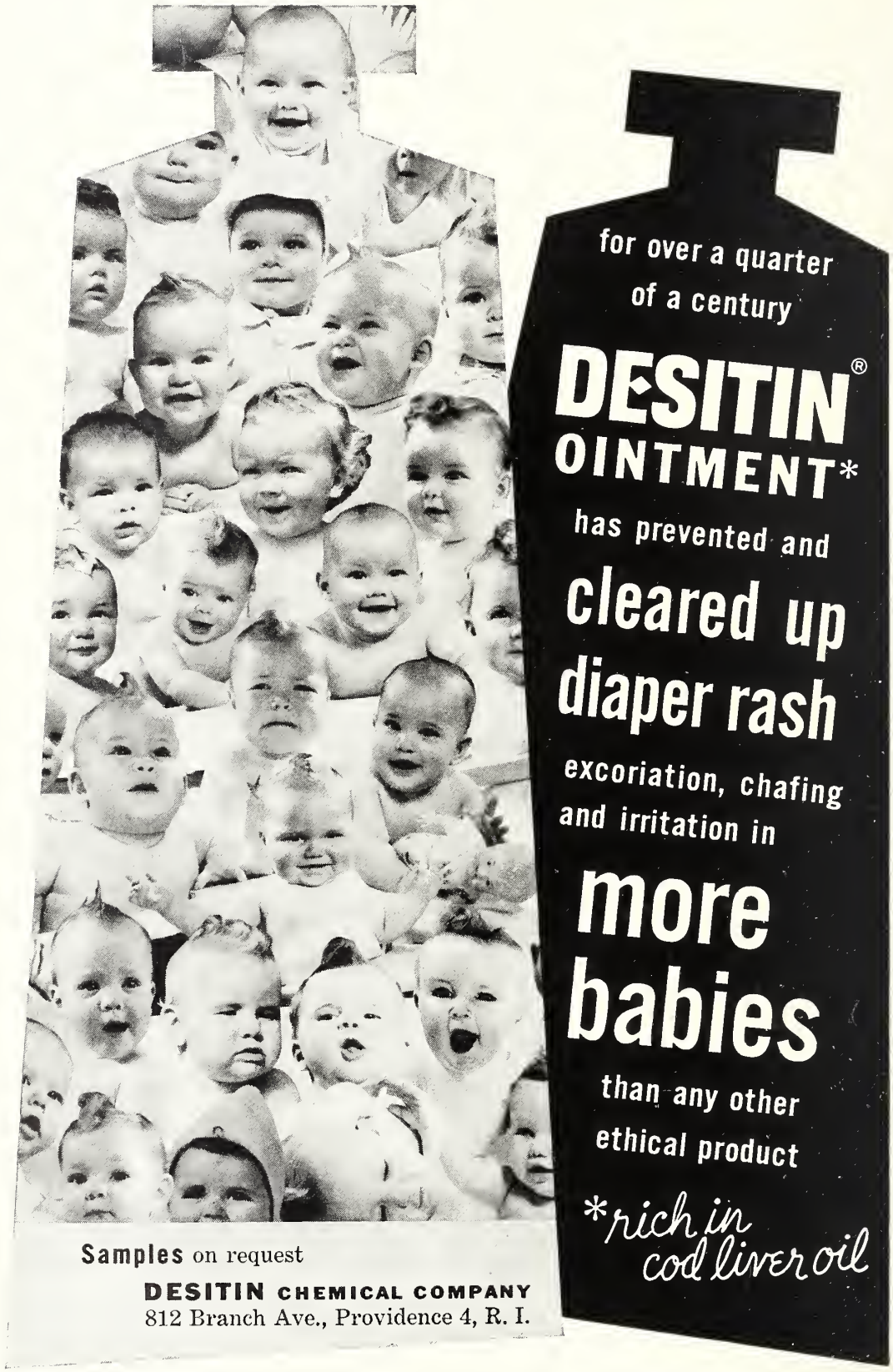
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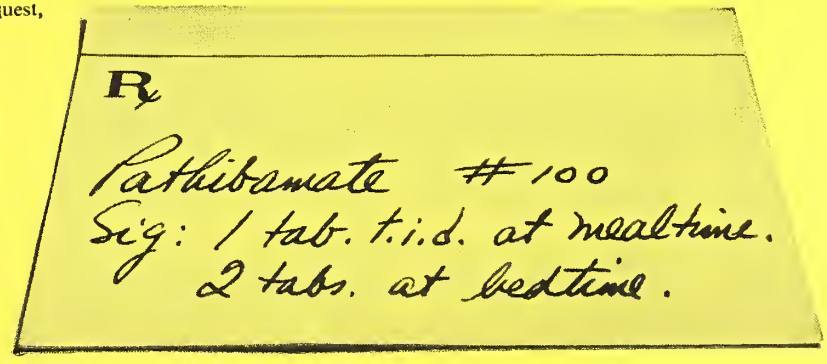
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References: 1. Borrus, J. C.: *M. Clin. North America,* In press, 1957. 2. Gillette, H. E.: *Internat. Rec. Med. & G. P. Clin.* 169:453, 1956. 3. Pennington, V. M.: *J.A.M.A.,* In press, 1957. 4. Cayer, D.: Prolonged Anticholinergic Therapy of Duodenal Ulcer. Am. J. Dig. Dis. 1:301-309 (July) 1956. 5. McGlone, F. B.: Personal Communication to Lederle Laboratories. 6. Texter, E. C., Jr.: Personal Communication to Lederle Laboratories. 7. Bauer, H. G. and McGavack, T. H.: Personal Communication to Lederle Laboratories.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Action of Epinephrine in Man, by Henry Barcroft, London, England, *(Josiah Macy Jr. Foundation, Packanack, N. J.)* The members may be interested in this contribution to the fourth conference on shock and hemostasis, published recently by the Josiah Macy Jr. Foundation. There is also a chapter in this conference proceedings on Pulmonary Circulation by Andre Cournaud, which is very worth-while.

Blood Group Substances: Their Chemistry and Immunology, by Elvin A. Cabat. ($8.00. *Academic Press, Inc., New York, N. Y.)* This is a book that all allergists will want to read. It is an attempt to bring together and synthesize existing information on the blood-group substances as seen from the viewpoint of quantitative immunochemistry.

Experimental Tuberculosis: Bacillus and Host, edited by G. E. W. Wolstenholme and Margaret Cameron. ($9.00. *Little, Brown & Company, Boston, Mass.)* This is the proceedings of the Ciba Foundation Symposium on the subject. It has nearly 400 pages packed with information about the reaction of the host to the tubercle bacillus, and therefore belongs in every library on bacterial allergy. There is also an addendum on experimental leprosy.

Structure of the Ego, by Lovell Langstroth. ($4.00. *Stanford University Press, Stanford, California.)* This book represents an anatomic and physiological interpretation of the psyche, based on the psychology of Otto Rank, who worked with Freud for more than 20 years. From the beginning, however, there was a fundamental difference of viewpoint. Freud believed that the origin of restraint in man's psyche was derived from outside factors, while Rank believed it arose in part from within. This view led to a dualistic psychology which enabled him first to develop a genetic psychology and then a will psychology. For some years the author has applied these principles to the treatment of neurotic patients, with a growing awareness of their clinical effectiveness.

Comparative Physiology of Reproduction, Endocrinology Memoirs No. 4, edited by I. Chester Jones, and P. Eckstein for the Society of Endocrinology. ($8.50. *Cambridge University Press, Cambridge, England.* United States Distributor, *Cambridge University Press, New York, N. Y.)* This memoir is based on the proceedings of a symposium held at the Department of Zoology at the University of Liverpool. This was an international meeting of endocrinologists, prepared to devote a major portion of the Conference to vertebrate classes, below the mammals. These scientists have presented an up-to-date picture of comparative endocrinology of vertebrates and have placed the old biological problems in the perspective of modern endocrinological concepts, at the same time relating newer ideas in this field to the facts of zoology.

Mind and Body, by Pedro L. Entralgo. ($3.50 *P. J. Kenedy & Sons, New York 7, N. Y.)* This is a short history of the evolution of medical thought. It emphasizes that psychology is as old as medicine itself. Medicine has always concerned itself with the mind as well as the body of the patient. The author traces this attitude from the earliest beginnings of medicine, through ancient Greece, the early Christian period, and down to the present time. He outlines in detail the modern developments in psychology and medicine, and has some startling and provocative theories about Freud.

Practitioners' Conferences at the New York Hospital Cornell Medical Center, Volume Three, edited by Claude E. Farkner, ($6.75. *Appleton Century Crofts, Inc., New York 1, N. Y.)* This is a record of bedside teaching. The conferences are intended to enable physicians generally to share some of the advantages of this great medical center. The scope is wide and the discussions are by all kinds of specialists.

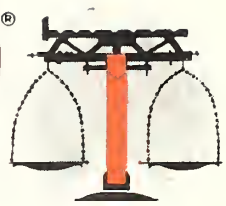
A Handbook of Marriage, by Ernest Parkinson Smith. ($1.50. Distributed by *The Sport Shelf, 10 Overlook Terrace, New York 33, N. Y.)* The author is a well-known consultant, and draws upon his own personal experience in this work to write a sympathetic, simple story of those experiences which can make or mar a marriage.

A Doctor's Marital Guide for Patients, by Bernard R. Greenblat, M. D. ($1.50. *Budlong Press, Chicago 25, Ill.)* Here is an extremely practical text which presents the necessary information which patients find hard to discuss with anyone but their doctor. This text appears in two editions, the regular one, and the one for Catholics (the latter, of course, eliminates the chapter on birth control and discusses the official viewpoint towards spacing of children and related subjects). The guide is only available through physicians.

The Sexual Responsibility of Women, by Maxine Davis, with an introduction by Lester Blumenthal, M. D. ($4.00. *Dial Press, New York 16, New York.)* The author has written monthly medical articles for *Good Housekeeping* for more than 11 years, and contributes to other magazines. This is an attempt by an experienced writer and

(Continued on Page 882)

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Human Ovulation and Fertility, by Edmond J. Farris, Ph. D. ($6.50. *J. B. Lippincott Company, Philadelphia, Pa.)* The executive director of the Wistar Institute of Anatomy and Biology has written this book as an aid to clinicians in the management of the problems of the childless couple.

The Essentials of Pathology, by Lawrence W. Smith, M. D. ($12.00. 3rd edition. *The Blakiston Company, Philadelphia 5, Pa.)* This text departs from many of the time-honored methods of presentation. First, it is a practical book. Second, it follows a middle course in presenting controversial topics; third, the pathology of parasitic infections has been given more than the usual attention as the world decreases in size; fourth, tumors are likewise emphasized to a greater extent than is customary. The author introduces case-history methods into the elementary classes in pathology.

Manual of Industrial Medicine, by Lemuel C. McGee, Ph. D., M. D. ($3.00. 3rd edition. *University of Pennsylvania Press, Philadelphia 4, Pennsylvania.)* It is becoming increasingly evident that the employees' health is of primary concern to industrial management and all physicians must now interest themselves in the impact of the patient's occupation upon his health. Although the physician may never be employed by industry, his service to his patients can be improved by his knowledge of the conditions surrounding the patient's job. The medical director of the Hercules Powder Company has written this manual with these facts in mind.

The Practice of Psychiatry in General Hospitals, by A. E. Bennett, M. D., Eugene A. Hargrove, M. D., Bernice Engle, M. A., with many contributing authors. ($4.00. *University of California Press, Berkeley and Los Angeles, Calif.)* This book is needed because the general hospital in the United States today is becoming a "general" hospital in fact as well as in name; patients once excluded from admission because they were suffering from mental illness, alcoholism, or drug addiction, are now being admitted in increasing numbers. Moreover it is the recommendation of medical, economic, and social agencies that psychiatric units be established in general hospitals. The operation of such units presents many problems unfamiliar to the administrators and to the medical men, including psychiatrists themselves. This volume answers many of the questions which must be considered in setting up such a unit.

Electrodiagnosis and Electromyography, edited by Sidney Licht, M. D. ($10.00. Published by *Elizabeth Licht, 360 Fountain St., New Haven, Connecticut.)* This is the first volume of the Physical Medical Library put out by this publisher. Some dozen contributors introduce us to the clinical applications of electroneurophysiology. This is the first book devoted to both subjects. In electrodiagnosis a current is admitted to a muscle to evoke contraction. In Electromyography the reverse occurs; a current is evoked from a muscle contraction. To round out the discussion there is a brief synopsis of encephalography, and the newest procedure related to this field: electroretinography.

Urology, by B. G. Clarke, M. D., and Louis Del Guerico, M. D. ($6.50. *Blakiston Division, McGraw Hill Book Company, New York 36, N. Y.)* Here is both text and reference on the essentials of urology. It presents this clinical subject as an area within the study of general biology and medicine, rather than as a specialty. It is a concise book brief enough to be read during the Urological Lectures or to be used in Board Reviews. It uses diagrams and pictures freely in place of detailed written descriptions. The material is presented in terms of pathology, embryology, physiology, bacteriology and biochemistry.

The Health Yearbook, 1955, compiled by Oliver E. Byrd, M. D. ($4.50. *Stanford University Press, Stanford, Calif.)* In his collection of material for the year, the author has changed this very useful book in several respects. The date of publication has been changed so that each volume will include articles appearing during the calendar year beginning January 1 and ending December 31. New sections have been added on physical fitness, dental health, sight, hearing, and speech. The author read more than 1800 articles in order to screen out the 261 which occur in the 13th volume of the series.

Cardiovascular Innervation, by G. A. G. Mitchell, M. D., D. Sc. ($11.00. *E. and S. Livingstone Ltd., Edinburgh,* U. S. Distributors *Williams and Wilkins, Baltimore, Md.)* Works on the anatomy of the nerves supplying the cardiovascular system are few indeed, and correct accounts are rarer still. Yet this is a matter of great importance to the clinician. Heretofore he has had to rely on texts and diagrams, with rare exception of authenticity. Now he has in this book a really helpful guide.

Progress in Hematology, Vol. I, 1956, edited by L. M. Tocantins, M. D., with 27 contributors. ($9.75. *Grune & Stratton, New York 16, N. Y.)* This is a periodic survey of the "various hematological task forces" now at work. The chronicler of the facts and events for each group has been selected because of his close participation in and familiarity with the activity in his field.

Patterns of Mothering, by Sylvia Brody, Ph. D., with introduction by Rene Spitz, M. D. ($7.50. *International Universities Press Inc., New York 11, N. Y.)* Refreshingly free of the old

(Continued on Page 884)



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cliches and pat labels, this book gives a picture of mothers' ways of handling babies based on the study of the behavior of 32 mothers of infants in the first half-hour of life. It describes a research study according to the spirit of psychoanalysis. The author began her work with direct observation of behavior and found her way back to the problems of psychic conflict.

Cytology of the Blood and Blood-Forming Organs, by Marcel Bressis, ($22.00. *Grune & Stratton, Inc., New York 16, N. Y.)*, translated from the French by Eric Ponder. In this study, descriptions as found in classical hematology are presented, but they occupy a secondary place in comparison with the description of the results of studies of cells in their living state and of their ultra structure as seen with the electronic microscope.

Anatomy for Surgeons, Vol. 2, dealing with the Thorax, Abdomen, and Pelvis, edited by W. Henry Hollinshead, Ph. D. ($20.00. *Hoeber-Harper Publishers, New York 16, N. Y.)* This series of books attempts to present in readable form that region of anatomy which is of particular importance to the surgeon. It describes and interprets the facts and concepts which the surgeon will find useful.

Campbell's Operative Orthopedics, edited by J. S. Speed and Robert A. Knight. ($40.00. 2 vols. *C. V. Mosby, St. Louis, Mo.)* This revision includes the discoveries occasioned by the impact of World War II and the innumerable changes which have followed in orthopedics since that time. The books are encyclopedic in character.

Midwifery, by Christie R. Brown, M. D., Barton Gilbert, M. D., Donald B. Fraser, M. D., and R. H. Dobbs, M. D. ($5.00. 4th edition. *Edward Arnold Ltd., London*, distributed in America by *Williams & Wilkins, Baltimore, Md.)* It is now 15 years since the first edition of this book appeared. Recent advances in the field, particularly as they relate to the midwife, made it necessary to revise the old text and include new chapters on antenatal pediatrics and ovarian and placental hormones. It is written for the purpose of training the midwife to think rather than to remember, although it recognizes that knowledge acquired by the appreciation of basic principles and their application is seldom forgotten.

Modern Man, by Montagu Ashley. ($.60, paper. *Science Research Association, 57 W. Grand St., Chicago, Ill.)* This is a booklet dealing with the history of man, by the Chairman of the Department of Anthropology at Rutgers. It is a fascinating story of man, his early ancestors, and his development.

They Stand Apart, edited by J. Tudor Reese, D. L., J. P., and Harley V. Usill, B. A., with four other contributors. ($3.75. *Macmillan Company, New York, N. Y.)* This is a critical survey of the problem of homosexuality, a problem which is becoming increasingly serious in the United States and Great Britain. Among the many difficulties in dealing with this subject is the fact that the general public is so ill informed. This study sets out objectively all relevant factors affecting the problem, bearing in mind that there are two parties to be considered, society and the individual, each having an inherent right to be safeguarded. This survey is without doubt the most authoritative and thorough book on the subject.

Noradrenaline: Chemistry, Physiology, Pharmacology, and Clinical Aspects, by U. S. Von Euler, M. D. ($11.50. *C. C. Thomas Co., Springfield, Ill.)* This is another in the series of Bannerstone American Lectures in physiology. It is intended for biologists, pharmacologists, biochemists, and those in the general profession who want more knowledge about the neurohormone which largely regulates the blood circulation in health and disease. This group includes, of course, the surgeon who in his work deals with sympathetic nerves and pheochromocytoma, or uses spinal anesthetics. Likewise it will interest internists who want to use vasoconstrictor substances and the anesthetist who may encounter sudden circulatory collapse on the operating table.

Supplement No. 1, Atlas of Exfoliative Cytology, by George N. Papanicolaou, M. D. ($4.00. Published for the Commonwealth Fund by *Harvard University, Cambridge, Mass.)* This supplement presents comparative illustrations of cells as seen in a tissue section and in a smear, thus bringing out clearly not only similarities but also the dissimilarities which are often marked. Sixteen plates find their proper place in the original atlas. It was because of the problem of production of such a supplement that the original Atlas was produced in loose-leaf form.

Morphology of Human Blood Cells, by L. W. Diggs, M. D., with Dorothy Sturm, B. A., and Ann Bell, B. A. ($12.00. *W. B. Saunders Co., Philadelphia.)* Many of these sketches we have seen in Abbott's "What's New." This is primarily a visual aid for medical students and technologists who for the first time are learning about the appearance of normal and pathological blood cells. Emphasis is placed on characteristics of individual cells and on differential structure, rather than on disease. Dorothy Sturm's water colors of the cells add much to the value of the book.

Clinical Orthopaedics, edited by Anthony F. DePalma with the assistance of associate editors. ($7.50. *J. B. Lippincott Co., Philadelphia, Pa.)* This is number seven in a series of monographs on subjects of outstanding interest. This volume deals with tumors of the bone. There is also a special third section on motorists' injuries and motorists' safety.

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JONATHAN FORMAN, M. D., *Editor*

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Are the Venereal Diseases Really Conquered?

HUGO HECHT, M. D.

VENEREAL Diseases would appear to be really conquered if we look at the behavior of the leading factors: First, the *Venereal Diseases Information* went out 1954; the *American Journal of Syphilis, Gonorrhoea and Venereal Diseases* ceased to be published, and the editors of the *A. M. A. Archives of Dermatology and Syphilology* cut off the last words and are now officially—at least according to the title—only a dermatologic publication.

To the author of this article it seems to be too optimistic to neglect the problem of venereal diseases completely. At the present, there is not one periodical in the U. S. A. dedicated to research and clinical reports of V. D. This is wrong!

First, there are also venereal diseases other than syphilis. The frequency of gonorrhea has not changed much; only due to modern remedies the patients with gonorrhea are cured in a shorter time. Complications as epididymitis, cystitis, prostatitis in men and oophoritis and salpingitis in women are very rare, because the infection is stopped before it has time to develop the mentioned complications. But gonorrhea is still one of the most frequent diseases! The cause—promiscuity. The greater part of the population is not monogamous. This is a fact and every practicing physician will verify this if he permits himself to be free of moral and religious prejudice. We have to face the facts.

This situation was much worsened during the last war which sent many of our men and women to all parts of the world. And after the war, the increased travel facilitated the opportunity for infection. Even if we could thoroughly control the population in our country it is impossible to control the millions of visitors from all over the world who come year after year to the U. S. A., and the Americans returning from their trips from abroad.

This view seems to be confirmed by figures published for the calendar year 1954 from the National Office of Vital Statistics.[1] According to Dr. C. A. Smith the reported cases of gonorrhea have gone up 1.5 per cent for the first time since 1947. This does not seem much but it is important as a symptom of decreased efforts in fighting venereal diseases until eradication. This is corroborated by another report[2] by the Association of State and Territorial Health Officers, the American Venereal Diseases Association, and the American Social Hygiene Association. It shows that 25 states and 14 major cities had in 1955 increases in the attack rate of syphilis or gonorrhea, or both.

Venereal diseases could only be eradicated with a world-wide campaign by an international organization as the World Health Organization with the consent and active help of all governments concerned—this means the whole planet.

The Author

● Dr. Hecht, Cleveland, is dermatologist, Mount Sinai Hospital.

Read at the First International Symposium on Venereal Diseases and the Trepanomatoses, May 28 - June 1, 1956, Washington, D. C.

It will take a few more centuries to achieve this cosmopolitan goal.

But this is not all. We have to change our attitude toward venereal diseases. In a very popular column (Dr. Alvarez) one could read recently a sentence about "women and children, who had received it (syphilis) innocently." Innocently? Is sex life a sin or crime in modern time? It seems so because many magazines and newspapers avoid mentioning the very words "syphilis" and "venereal diseases." So do some doctors and many, too many—cultured and well educated people. The mental development of our generation did not keep in step with the tremendous progress of science.

NONGONORRHEAL URETHRITIS

Not changed at all in frequency are the different forms of nongonorrheal urethritis. Not much is known about frequency; this author's estimation is that it is twice and a half as frequent as gonorrhea. There is no doubt that nongonorrheal urethritis has many causes: nonbacterial and bacterial.

The nonbacterial nongonorrheal urethritis can be caused by mechanical, thermic, caustic and chemical agents. To the latter group belong irritation through indiscriminate use of prophylactics.

Many infectious diseases can cause nongonorrheal urethritis such as typhoid, tuberculosis, meningitis cerebrospinalis, syphilis, measles; also bacteria other than gonococci are known to irritate the urethra: Staphylococci, Streptococci, Diplococci, and bacilli which are normally present in the urethra and vagina. It is not known why these nonpathological microorganisms become infectious in certain persons. Much investigation was done on the urethritis caused by inclusion bodies (Einschlusskörperchen) described by Halberstädter and Prowazek and later by Reiter.

Many cases of nonbacterial nongonorrheal urethritis are of the type described by L. Waelsch: long incubation period, slow development, white secretion and protracted course. In recent years a form of nongonorrheal urethritis became known to be caused in men by Trichomonas vaginalis. In spite of the frequency not much research is dedicated to this kind of infection.

It seemed necessary to recall these facts about nongonorrheal urethritis because it is rarely mentioned or discussed at medical meetings or in medical journals. And yet—we have two and one-half times more urethritis nongonorrheal than gonorrhea.

The practitioner is inclined to treat all patients with penicillin. The effect is minimal in nongonorrheal urethritis. Much better results can be obtained with streptomycin or Ilotycin.® But some of the nongonorrheal urethritis clears up without any medication at all if not irritated by improper treatment. This fact is too often overlooked by the practicing physicians. But the indiscriminate use of penicillin by practitioners also has unwanted consequences: some patients are allergic to penicillin and suffer greatly from unnecessary treatment. And some could become resistant to it so if it is administered later in case of a real emergency, it fails to work.

OTHER VENEREAL DISEASES

But there are also the granuloma venereum and granuloma inguinale which are quite frequent in the South where the hygienic conditions are not what they could and should be. There is still the ulcus molle (chancroid) in the same group as the granulomas, even if now less frequent than 20 years ago because chancroid is a disease of people who are not used to physical cleanliness. In German literature the chancroid was called "Schmutzkrankheit" a disease aggravated by dirt. It is very rare now in private practice.

Most of the patients with a venereal disease come

TABLE 1—UNIVERSITY HOSPITALS OF CLEVELAND

Summary of All Syphilis Tests Performed at the Main Laboratory on In-Patients, Outpatients and Blood Samples Sent by Physicians.*

Year	Lakeside		Private		McDonald		OPD		B & C		Blood Bank		Misc.		Rainbow		Benj. Rose	
	Kline	Wass.	Kline	Wass.	Kline	Wass.	Kline	Wass.	Kline	Wass.	Kline	Wass.	Kline	Wass.	Kline	Wass.	Kline	Wass.
1948	4169	545	4789	195	5369	538	7616	2422	1955	60	3190	64	889	507	6	11		
1949	4044	468	5043	195	5355	460	7981	2468	2429	42	3625	50	672	421	5			
1950	3813	387	5091	145	4590	334	8405	2435	2127	26	4132	35	481	317				
1951	4150	358	5488	123	5896	398	6309	1925	1957	15	4269	56	411	246				
1952	4445	362	5317	499	5139	284	4946	1292	2877	91	3216	22	314	207				
1953	3452	385	4592	135	4099	268	3731	1226	1322	14	2528	25	164	104	21		36	1
1954	4010	338	5416	216	4686	254	3348	1058	1804	37	2489	34	203	75			48	3

Total	Year	Kline	Wassermann
	1948	27,983	4,342
	1949	29,154	4,104
	1950	28,639	3,679
	1951	28,480	3,121
	1952	26,254	2,757
	1953	19,945	2,158
	1954	22,004	2,015

*This excellent summary of syphilis tests over seven years cannot be used for this investigation because the cases are not divided according to the results of the syphilis tests in groups of negatives, strongly and weakly positives.

TABLE 2—CASES OF SYPHILIS REPORTED TO THE CLEVELAND DIVISION OF HEALTH.

Year	Total	I & II	Early latent	Late latent	Cardiovasc.	Neuro-syphilis	Congenital
1950	2002	137	683	Late syphilis		1121	61
1951	1695	113	621	Late syphilis		922	39
1952	1400	80	470	762	0	53	35
1953	1372	41	431	821	7	41	40
1954	2054*	55	425	1474	18	31	51

*Mass Blood Testing Project in 1954 was responsible for the increase in the number of cases of syphilis reported during that year.

today first to the general practitioner not aware of the specialization the practice of medicine underwent in the last 20 years. The tremendous progress of medicine makes it impossible for the single physician to be competent in all fields; through work of the Academy of General Practice the prestige and knowledge of the general practitioner rose eminently, aided by refresher courses attended by many of them. But only specialization can give a perfect knowledge in a special field. There is still the question of ethics valid: What is better for the patient? The answer gives the old Latin saying: *Salus aegrorum suprema lex!* And this means treatment of V. D. by specialists.

STATISTICS

Recent statistics show that venereal diseases are still far from extinction. In 1954 nearly 250,000 cases of gonorrhea were reported in the U. S. A.[3] The U. S. Public Health Service[4] estimated that 2,000,000 persons in the United States need treatment for syphilis. In 1954 there were 8,000 cases of syphilis reported in Ohio; 75,000 Ohioans are in need of treatment for syphilis.[5] The accompanying tables tabulate statistics from Cleveland, Ohio.

Significant is the decline of fresh infections with syphilis and not less the increase in the number of late latent syphilis. The latter means that many cases were not recognized at the beginning or not properly treated over the years. It is to be expected that in a few years from now many cases of neurosyphilis, tabes dorsalis and general paresis will make their appearance in the offices of the practitioners.

The cases reported to the Cleveland Division of Health (table 2) come partly from the later mentioned hospitals. Therefore this statistic duplicates the singular ones from the hospitals. The hospital reports are more reliable because they include also the not reported private cases of syphilis. We cannot expect a complete statistic without a law for compulsory reports from all doctors and institutions, and a centralized card index. Only one country in the whole world has such a reliable system—Denmark.

For about 40 years all syphilis tests performed in the State Institute in Copenhagen are indexed there. Of course, Denmark has only about four million inhabitants. The city of New York has more than twice as many people. Imagine the gigantic task if the United States would try to introduce a similar system. It is of course not impossible if the organization of the Public Health Service would be used as basis establishing county, state and federal card files. Even privacy could be assured by reporting the patients only with the initials of the full name, the birth date, profession, place of birth, and name of the reporting doctor, respectively, for the institution. Even in the U. S. A. a duplication of these five factors would be an exception.

Table 3 gives a better idea about the frequency of syphilis than the former statistic which is based on voluntary reports by physicians. We have to face the fact that few practitioners report their patients with venereal diseases. To get a true picture, reporting of all cases of V. D. should be made compulsory by law and enforced. In practice, gonorrhea is not reported at all and syphilis only when the physicians send the blood of their patients to the City Laboratory for a free test.

The statistics from the hospitals are relevant because they refer to all patients whose blood was tested as a matter of routine. We have

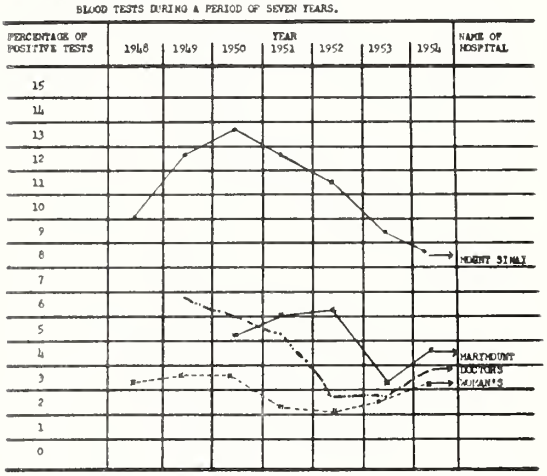
TABLE 3—MOUNT SINAI HOSPITAL IN CLEVELAND, OHIO

Summary of all syphilis tests performed at the Main Laboratory on in-patients, outpatients and blood samples sent by physicians.

Year	Total tests	Negative	Positive		Average
			more than ++	less than ++	
1948	11 657	10,484	945/8.11%/	228/1.95%/	10.06%
1949	13,394	11,682	1404/10.52%/	303/2.26%/	12.78%
1950	13,889	11,949	1491/10.73%/	449/3.23%/	13.96%
1951	14,164	12,346	1422/10.03%/	396/2.79%/	12.82%
1952	15,152	13,404	1392/9.18%/	356/2.34%/	11.42%
1953	15,447	14,018	1133/7.34%/	296/1.93%/	9.27%
1954	15,218	13,869	1006/6.61%/	343/2.26%/	8.87%

to keep in mind that this routine detects many unknown infections of patients; but some of the positive tests are not caused by syphilis. It is difficult to state how many belong to this group. In the experience of the author[6] they appertain more to the group with a weakly positive test. It must also be known that some of the patients are tested twice or more a year so that the

PERCENTAGE OF POSITIVE SYPHILIS TESTS IN FOUR CLEVELAND HOSPITALS WITH 180,833 BLOOD TESTS DURING A PERIOD OF SEVEN YEARS.



percentage of positive tests gained through the quoted accompanying statistics is a little too high. But the results gained by this method are nearer to the real situation than the ones which rely only on the reported cases because only the hospitals and dispensaries report regularly. Many private physicians do not report all their syphilis cases and never report patients with other venereal diseases.

The difference in the percentage of positive tests in various hospitals can be explained with the different groups of population the hospital attends to. The highest percentage of positive tests is found at Mount Sinai Hospital which has not only private and charity patients but also big outpatient departments. It has probably the highest number of non-white patients. The highest percentage of syphilis and other venereal diseases is known to be in the colored population. There are several factors involved:

1. The lower living standard in crowded quarters. The children are therefore very early exposed to the facts of sexual life with all the consequences such as early pregnancy and infections with V. D., incest not being excluded.

2. Less education and less knowledge about venereal diseases and preventive measures.

3. Less medical attention.

4. Another moral standard. Polygamy may not be legal but it is factually practiced.

Next to Mount Sinai Hospital comes Marymount Hospital which has charity and private patients, both white and colored. Third in our grading is Doctors Hospital which is a private Hospital without any charity patients. A few colored patients are admitted. Fourth is Woman's Hospital, the smallest of these four hospitals and also private without charity and only a few colored patients. One other factor than mentioned in the foregoing is to be regarded: the different tests used in the laboratories. Very

TABLE 4—MARYMOUNT HOSPITAL, GARFIELD HEIGHTS
Summary of All Syphilis Tests Performed at the Main Laboratory on In-Patients, Outpatients and Blood Samples Sent by Physicians

Year	Total Tests	Negative	Positive		Average
			more than ++	less than ++	
1950	2932	2823	135/4.60%	24/0.82%	5.42%
1951	3061	2875	138/4.50%	48/1.57%	6.07%
1952	4452	4169	190/4.25%	93/2.09%	6.34%
1953	5870	5668	150/2.56%	52/0.89%	3.45%
1954	6239	5955	180 2.88%	104/1.67%	4.55%

TABLE 5—THE DOCTORS HOSPITAL
Summary of all Syphilis Tests Performed on In-Patients and Outpatients

Year	Total Tests	Negative	Diagnostic	Exclusion	Pangborn	Average
1949	4,625	3,621	Less than ++ 238/5.14%	256/5.53%	153/3.31%	
			More than ++ 83/1.79%	144/3.11%	130/2.81%	6.93%
1950	4,123	3,397	Less than ++ 157/3.80%	172/4.17%	122/2.95%	
	Total 5,571		More than++ 61/1.47%	109/2.64%	105/2.54%	
Cardiolipin 1950	1,448	1,373	More than ++ 22/1.15%		Less than ++ 53/3.66%	6.42%
1951	5,993	5,676	More than ++ 132/2.20%		Less than ++ 185/3.08%	5.28%
1952	6,876	6,654	More than ++ 94/1.36%		Less than ++ 128/1.61%	2.97%
1953	6,712	6,501	More than ++ 111/1.50%		Less than ++ 100/1.48%	2.98%
1954	6,407	6,170	More than ++ 156/2.43%		Less than ++ 81/1.26%	3.69%

TABLE 6—WOMAN'S HOSPITAL

Summary of All Syphilis Tests Performed at the Main Laboratory on In-Patients, Out-Patients and Blood Samples Sent by Physicians.

Year	Total Tests	Negative	Positive		Average
			more than ++	less than ++	
1948	2,107	2,041	30/1.42%/	36/1.70%/	3.12%
1949	1,968	1,904	23/1.15%/	41/2.08%/	3.23%
1950	2,888	2,789	53/1.83%/	46/1.59%/	3.42%
1951	3,949	3,846	60/1.51%/	43/1.08%/	2.59%
1952	3,821	3,748	41/1.33%/	32/0.83%/	2.16%
1953	4,098	3,991	35/0.87%/	72/1.75%/	2.62%
1954	4,343	4,193	61/1.40%/	89/2.05%/	3.45%

sensitive tests give more positive results. It would be a great advantage if all laboratories could agree on one technic and the same antigen. Statistics under those circumstances would surely be more reliable than they are today.

FLUCTUATION OF VENEREAL DISEASES

Also venereal diseases are subjected to epidemiological fluctuations as are many other diseases. The cause of this phenomenon is not clearly explained. Many authors think that economic factors are of great importance (Haustein; Buschke and Langer). Others claim statistical-epidemiological laws are of decisive influence (E. v. Düring, E. Delbanco, K. Herxheimer, Gumpert, E. Finger). The seasonal fluctuations of V. D. are influenced by the warm season and holidays (Christmas, carnivals, Sundays and week ends).

There is a parallelism in frequency between venereal infections and alcohol consumption as was proved many years ago by A. Forel, Langstein, Hecht and others. It is still so: the pay days and week ends are also the days of excessive consumption of alcohol and a maximum of venereal infections. This is especially true for married men. About 75 per cent of them get infected only under the influence of alcohol—the moral inhibitions are weakened if not drowned in the flood of alcohol—the knowledge of danger is neglected by omitting protection or desinfection—the partner is chosen without regard to reason.

During and after a war tremendous increase of syphilis and also of other infections can always be observed. This was so after World War I and probably also after World War II. A few years later came a natural decline of new infections because many presumptive candidates were infected prematurely due to the abnormal war conditions.

About 10 years later starts the upswing of new infections, economic conditions permitting. It was so in Europe and the United States after both World Wars. At this time the U. S. A. arrived at the point where new infections were becoming more frequent due to the great prosperity, and the maturing of the young generation. In 1954 nearly 250,000 cases of gonorrhea have been reported. But how many were not reported? The U. S. Public Health Service estimated that two million persons are at present in need of an antisyphilitic treatment in the United States.

ESTIMATED NUMBER OF SYPHILITICS IN CUYAHOGA COUNTY, OHIO

At the time being, the population of this county is 1,465,511. The frequency of positive syphilis tests in the years from 1948 to 1954 was 6.59, 7.64, 7.30, 6.69, 5.72, 4.58, and 5.11 per cent respectively. If we assume that there were at least 5 per cent seropositive syphilitics in Cuyahoga County we come to the surprising high figure of 73,165 seropositive persons. Taking into consideration that 10 per cent of these positive tests could be of nonsyphilitic origin, we assume that 65,850 persons have syphilis and need treatment. On the other hand many persons with an early primary lesion or with latent syphilis are seronegative.

We have also to keep in mind that during these seven years of our survey several tests were performed on the persons; it is impossible to guess the right number. My private opinion is that we come near the truth if we take one third of the last number mentioned in the foregoing as the minimum number of persons afflicted with seropositive syphilis and in need of treatment—21,950 persons the year around. For the U. S. A. with a population of 165 million this would be a minimum of about 2,420,000 syphilitics scattered all over the country. There are, in ratio, more syphilitics in big cities than in smaller ones or in farm lands and still more in great harbors as international centers of commerce. Therefore, venereal diseases in the U. S. A. are far from being extinct!

OTHER COUNTRIES

The situation with regard to syphilis is similar all over the world with the difference that rich countries like the United States can give more and better treatment than the others. The same is true with gonorrhea and the other venereal diseases. Only a few quotations:

In Bosnia exists syphilis as endemic (E. J. Grin[7]) in certain parts of the country. A report on syphilis control in Turkey (S. Christiansen[8]) shows the combined efforts of the Turkish Government and the W. H. O. The results are far from being satisfactory. A little better are the results in Czechoslovakia (J. Janda[9]) but there is still much work to do. Similar reports were presented by E. Kalman on the present

state of mass survey for syphilis in Hungary and by Király, J. Káldor and L. Kovács.[10]

Th. D. Elliott[11] reports from Norway that there the situation is well under control after a wartime increase which continued also after the war. The national rate in 1950 for acquired syphilis was 2.1 per 10,000 population and for all venereal diseases 9.6 per 10,000. It is similar in Sweden with regard to syphilis, but there is a slight increase in the rate of gonorrhea (20.8 per 10,000) and in 1952 for syphilis (0.47). Finland had in 1951 for syphilis a rate of 0.32 per 10,000; for gonorrhea, 10.8, and 14 for new cases of venereal diseases. The infections are as in Norway limited almost exclusively to the seaports.

In Denmark the venereal diseases were well under control before World War II, increased during the occupation and have since fallen rapidly. The rate was, in 1952, for gonorrhea 16.3 per 10,000 and for syphilis 0.5.

In Israel[12] syphilis is the main venereal disease. Its relation to gonorrhea is 24 to 1. But the number of V. D. patients is comparatively small in comparison with the United States: 0.7—0.8 per 1000 to 2.4 per 1000 in the U. S. A.

According to R. Sutherland[13] there can be assumed that the ratio of gonorrhea to syphilis in England and Wales is 2.6 to 1; that at least 3.5 per cent of the adult population has or had a venereal disease (one out of every 29 adults).

In France we find venereal disease downward as everywhere else[14] but still not conquered. A new law (April 24, 1946) is mainly concerned with the regulation and sanitation of prostitutes. A medical examination for candidates of marriages is compulsory[15] but the doctor has no power to prevent a marriage even if he finds one or both partners in an infectious state.

This short revue shows that we are not entitled to optimism in the near future. Much work is to be done in the field of health education, legislation, treatment and prevention.

CONCLUSIONS

The fight for control of venereal diseases is far from victory. It must be continued in intensified endeavour:

1. The present *teaching* of venereal diseases in American Medical Schools is not sufficient. It should be taught as special discipline by venercologists.

2. Every *practitioner* should know enough of diagnosis and treatment of V. D. to take care of the uncomplicated cases and be aware when to call in a consultant. They rely too much on laboratory tests. Courses on venereal disease should be compulsory for practitioners.

3. Treatment for the *patients without means* should be paid by cities, states and federal government. The patient should have the choice between dispensaries and practitioners. The latter ones should be directly paid for their work. Discretion should be granted. Only if a V. D. patient interrupts the treatment should the physician in charge report him to the health authorities. This is especially important for pregnant women with syphilis. Only so can the number of children with *congenital syphilis* be diminished.

4. The *social taboo of V. D.* should be lifted by giving it more attention in public lectures to PTA groups, church organizations and other cultural groups. The press could be of help. The knowledge of the existence of venereal diseases should also be stressed in all high schools by lectures incorporated into the biology, anatomy and physiology courses given to children over 16 years.

5. *A special group in the United Nations* should be organized to fight venereal diseases on a world-wide basis. This group should publish a special journal dedicated solely to matters connected with venereal diseases as diagnosis, treatment, research, prevention, legislation.

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Fatal Outcomes Reported in Many Cases of Candidiasis

Candida albicans is a saprophytic fungus which is a common inhabitant of the skin, nails, gastrointestinal tract, oral cavity and the female genital tract. Under normal conditions infections caused by this fungus were treated very complacently on the part of the profession. Although they were capable of producing a variety of metastatic visceral lesions as a result of the invasion of the blood stream. With the advent of penicillin during the past decade and later on with the introduction of the broad-spectrum antibiotic drugs to our chemotherapeutic armamentarium, increasing reports have been accumulating in the literature of cases of candidiasis of a localized and generalized nature, producing lesions involving the integumen as well as the gastrointestinal, broncho-pulmonary, genitourinary, cardiovascular system, and even the central nervous system with fatal outcomes in many of the cases.—Walter Kohn, M. D., Baltimore: *Maryland State M. J.* 6:254,May, 1957.

Coxsackie and ECHO Virus Infections in Ohio During 1956*

D. M. McLEAN, M.D., C. C. CROFT, Sc.D., J. T. PRINCE, B.S., and EDNA E. HECKMANN, B.S.

FOLLOWING the widespread application of tissue culture methods to the study of poliovirus infections, Syverton et al.[1] and Melnick,[2] it soon became apparent that many patients who were diagnosed as suffering from the aseptic meningitis syndrome, frequently labelled clinically as "nonparalytic poliomyelitis," were infected with Coxsackie or ECHO[3] viruses and not poliovirus. Clinically manifest infections with Coxsackie and ECHO viruses have frequently occurred sporadically as cases of aseptic meningitis during summer and autumn months, at a time when many cases of paralytic poliomyelitis occurred.[2]

When cases occur sporadically, usually a wide range of viruses is encountered. The present paper reports the isolation of four serologically distinct Coxsackie virus types and three ECHO virus types from the feces of 27 patients and spinal fluid of one patient affected with the aseptic meningitis syndrome in Ohio during 1956.

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CLINICAL ASPECTS

The illness which occurred in 28 patients with aseptic meningitis from whom a virus, distinct from poliovirus, was isolated was similar to that described in recent epidemics in Minnesota by Syverton et al.,[4] in eastern Canada by McLeod et al.[5] and in England by McLean and Melnick.[6] Briefly it consisted of headache, fever of above 100°F, and neck stiffness accompanied frequently by anorexia and vomiting. Pain in the chest or abdomen occurred in four patients. Paralysis or weakness of limbs was not found.

Of the 23 patients from whom cerebrospinal fluid findings were available all had pleocytosis. There were ten patients with a predominance of lymphocytes in the spinal fluid, and nine with segmented cells. The youngest patient encountered was 2 years of age and the oldest was aged 29 years. Eight symptomatic infections occurred among children aged 5 to 9 years, the age group most commonly affected. Ten patients had received two or three doses of trivalent formalinized poliomyelitis vaccine, three patients received one injection and 15 patients had not received any vaccine.

There was no widespread epidemic of aseptic meningitis in Ohio during the summer of 1956 but illnesses occurred sporadically, without evidence of contact with other cases, except for patients No. 268 and 270 who were brothers.

VIRUS STUDIES

Virus isolations. Feces which was obtained as soon as practicable after onset of illness was extracted with 10 volumes of Hanks balanced salt solution, centrifuged at 10,000 r.p.m. for 30 minutes and 0.1 to 0.2 ml. amounts were inoculated into stationary tubes of both monkey kidney cultures and HeLa cultures. Fluids from cultures which showed cytopathogenic effects during the first seven days after inoculation were inoculated into other cultures. If cytopathogenic effect occurred on further incubation, the fluids were harvested and held at −40°C. to await typing.

Virus typing. Viruses in their second passage monkey kidney or HeLa culture fluids were titrated in monkey kidney cultures. Dilutions of stock virus calculated to contain between 100 and 300 TCD_{50} were mixed with antisera prepared in monkeys against Coxsackie A9, B1 through B5, ECHO 1 through 13, in which the serum was diluted to contain at least 20 antibody units. Aliquots were inoculated into each of four tubes of monkey kidney cultures. A titration of the diluted stock virus was carried out simultaneously. Cytopathogenic effect was usually complete by the 4th to 7th day in all tubes except those which contained specific antibody against the virus. In the latter case no cytopathogenic effect was observed.

Neutralizing antibody titers against Coxsackie

*The laboratory work in Minneapolis was aided by a grant from the National Foundation for Infantile Paralysis and by a contract with the Communicable Disease Center, U. S. Public Health Service. The Division of Laboratories, Ohio Department of Health was aided by a contract with the Communicable Disease Center, U. S. Public Health Service.

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B3 virus were determined by inoculation of aliquots of serum-virus mixtures into each of four culture tubes containing HeLa cells. The antibody titers against Coxsackie A9 and the homologous viruses were measured in monkey kidney cultures. Sera were heated at 56°C. for 30 minutes and tested in dilutions of 1/10, 1/50 and 1/250 against virus pools diluted to contain between 100 and 300 TCD_{50} of virus.[7]

RESULTS

At the laboratories of the Ohio State Department of Health, viruses were isolated from 101 stool and one spinal fluid specimen out of 298, which were taken from patients or contacts of patients who suffered primarily from poliomyelitis or aseptic meningitis during 1956. Poliovirus was isolated from 28 patients with paralytic disease and from 40 patients with a nonparalytic illness (table 1). Of the remaining 34 isolates,

TABLE 1.—VIRUS ISOLATIONS FROM 298 PATIENTS WITH POLIOMYELITIS OR POLIO-LIKE DISEASE IN OHIO, 1956

Virus Isolation	Type of Disease	
	Paralytic	Nonparalytic
Poliovirus-1	23	34
Poliovirus-2	1	0
Poliovirus-3	4	6
Coxsackie or ECHO virus	0	34
Total	28	74

28 were studied further in the University of Minnesota Laboratories. Identification was made of eight strains of Coxsackie B2 virus, nine strains of Coxsackie B3, two strains of Coxsackie B5, four strains of Coxsackie A9, two strains of ECHO 6 and one strain each of ECHO 2 and ECHO 9. The viruses which were isolated from patients Nos. 75 and 105 were not neutralized by monkey antisera against Coxsackie A9, B1 through B5, ECHO 1 through 13. (See table 2.)

Viruses from all 28 patients multiplied in monkey kidney cultures to titers which ranged between $10^{3.9}$ to $10^{7.9}$ TCD_{50} per ml. Viruses were isolated from stools collected as early as one day after onset and as late as 24 days, but 19 of the 28 strains were from feces obtained seven days or less after onset. Coxsackie B3 virus was isolated from the cerebrospinal fluid of one patient, No. 220. Coxsackie B2 and B3 strains, although isolated from the patient by inoculation of fecal extract into cultures of HeLa cells on some occasions, gave low titer irregular end points when titrated in HeLa cultures. However, these strains multiplied to high titer in monkey kidney cultures. Virtually all identifications of viruses were made in kidney cultures.

Of 13 serum pairs which were examined against Coxsackie B3 virus, one pair had no antibody in the early specimen but a rise in titer was detected subsequently, eight had elevated titers in both early and late serum samples and four had no antibody in either serum sample. Four of the patients who had antibody in one or both samples excreted Coxsackie B3 virus. Seven serum pairs were examined for antibody against Coxsackie A9 virus. One patient had a rising titer of antibody and he was excreting Coxsackie A9 virus in his stool, two had antibody in both early and late sera with virtually no change in titer, and four had no antibody in either serum.

Of eight serum pairs which were tested for antibody against the virus which the patient was excreting, two had no antibody in the first serum sample but antibody was detected in a later sample and six had antibody at approximately the same titer in both early and late sera. Thus Coxsackie A9, B2 and B3 viruses caused infection in patients Nos. 103, 153, and 268 respectively at the time of their illnesses.

TABLE 2.—VIRUS ISOLATIONS AND ANTIBODY STUDIES ON 28 OHIO PATIENTS WITH ASEPTIC MENINGITIS.

Type of virus isolated	Patient's number	Days after onset	Neutralizing antibody in patient's sera: Coxsackie B3	Coxsackie A9	Homologous virus
Coxsackie B3	96	7	250+	0	100
		18	250+	0	100
	248	6	250	–	250
		19	250	–	250
	268	2	0	–	0
		17	100	–	10
	270	2	100	–	10
		17	250	–	20
	100, 185, 189, 209, 220	–	–	–	–
Coxsackie B2	153	2	100	0	0
		22	100	0	250+
	161	1	0	100	–
		40	0	50	–
	164	2	0	0	–
		13	0	0	–
	162, 195, 200, 239	–	–	–	–
Coxsackie A9	103	5	0	0	–
		21	0	20	–
	187	2	20	100	–
		35	50	100	–
	121, 226	–	–	–	–
Coxsackie B5	148	5	100	–	–
		19	250	–	–
	150	–	–	–	–
ECHO 6	102	2	30	–	50
		28	50	–	100
	256	–	–	–	–
ECHO 2	99	–	–	–	–
ECHO 9	76	–	–	–	–
Not typed	75	5	20	–	20
		30	20	–	10
	105	7	0	0	10
		24	0	0	20

Titer of serum 0 indicates <10
– indicates no test

CASE REPORT

Patient X., a 5 year old boy, was admitted to hospital on December 21, 1956, with fever (101.4°F.), rapid thready pulse (rate 116), rapid breathing (rate 40), pallor and an enlarged

heart, which finding was confirmed radiologically. The apex beat was in the midaxillary line, the liver was felt 2 finger breadths below the right costal margin, the spleen was palpable but there was no edema. An electrocardiogram taken two days after admission showed evidence of myocardial damage (T waves inverted in all leads).

The patient was kept in an oxygen tent one day prior to his admission to hospital and the tent was removed after three days, following considerable improvement. He also received digitoxin 0.05 mg. daily and penicillin 300,000 units daily while in hospital. He was asymptomatic on discharge 11 days after admission.

Coxsackie B2 virus was isolated in monkey kidney cultures from feces collected 16 days after onset of myocarditis. Serum collected on the 12th day after onset had an antibody titer of 10 when tested against 1000 TCD_{50} of the patient's own virus strain and serum samples which were collected 23 and 86 days after onset both had titers of 50. It seems reasonable to infer that Coxsackie B2 virus could have been the etiological agent in this case of acute myocarditis.

Coxsackie B3 virus was incriminated as the cause of acute myocarditis in a newborn infant by Kibrick and Benirschke.[8] The foregoing findings show that another member of the Coxsackie B group of viruses type B2, may cause acute myocarditis.

DISCUSSION

The wide range of Coxsackie and ECHO virus types which were recovered from patients affected with the aseptic meningitis syndrome throughout Ohio during the summer and autumn of 1956 is in sharp contrast to the epidemic of aseptic meningitis in Minnesota during the same period which was caused by one antigenic type only, Coxsackie B5.[4] Of the non-polioviruses encountered in Ohio in 1956, the majority were Coxsackie A9, B2 and B3 but there was no clear preponderance of one antigenic type over another. On the contrary, of the 43 non-polioviruses recovered from patients who developed aseptic meningitis in Connecticut in 1955 by Davis and Melnick,[9] 21 viruses were typed as ECHO 6, 18 viruses belonged to the Coxsackie group and four were not typed.

In Ohio there was no true epidemic, but the virus strains were isolated from patients who developed aseptic meningitis without direct evidence of spread of infection from patient to patient except in the case of patients Nos. 268 and 270 who were brothers and both became ill at the same time following infection with Coxsackie B3. During the same months in which 28 Coxsackie and ECHO viruses were isolated from nonparalytic patients, 40 strains of poliovirus were isolated from other nonparalytic patients and 28 poliovirus strains were isolated from patients with paralytic poliomyelitis. It is of interest to note that antibody titers against *Leptospira icterohemorrhagiae*, *pomona*, or *canicola* were found in sera from four patients with the aseptic meningitis syndrome.

In the present study we did not encounter mixed infections with poliovirus and Coxsackie virus in contrast to Melnick et al.[10] who found that patients were infected simultaneously with both Coxsackie virus and poliovirus during an outbreak of "summer grippe" in Ohio in 1947. It is interesting to note that the Redmond strain of Coxsackie B2 virus was recovered by Melnick et al.[10] from a nonparalytic patient in Summit County where three strains of Coxsackie B2 virus were isolated during 1956.

SUMMARY

Viruses were isolated from 102 stool specimens out of 298 which were submitted from patients resident in Ohio during 1956 who were diagnosed as suffering primarily from poliomyelitis, both paralytic and nonparalytic. Poliovirus-1 was isolated from stools from 23 paralytic patients and 34 nonparalytic patients, poliovirus-2 was isolated from one paralytic patient, poliovirus-3 was recovered from four paralytic and six nonparalytic patients.

Of 28 cytopathogenic agents, not poliovirus, which were recovered from nonparalytic patients, nine strains were Coxsackie B3 (including one isolation from cerebrospinal fluid), seven strains were Coxsackie B2, four strains were Coxsackie A9, two strains were Coxsackie B5, two strains were ECHO-6, there was one strain each of ECHO-2 and ECHO-9 and two viruses were not typed. Coxsackie B2 virus was isolated from the feces of one patient who had acute myocarditis and a rising titer of neutralizing antibody against this virus was subsequently detected.

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An Evaluation of Phenylbutazone As an Antiarthritic Agent

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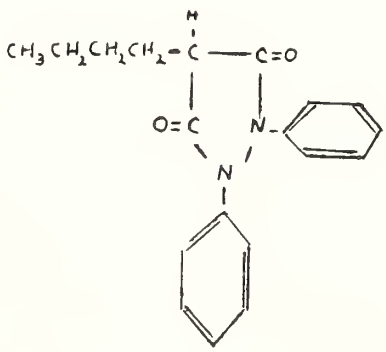
FOR several years, because of a number of reports which dealt almost exclusively with toxic reactions to phenylbutazone (butazolidin®), we hesitated to use the drug in this clinic. Eventually, however, the accumulation of impressively favorable observations recorded by distinguished authorities on arthritides[1-17] induced us to begin cautious trial of phenylbutazone, with the utmost circumspection as regards selection and supervision of patients. Our initial results have been definitely worth while, and our use of the drug has therefore been extended to more and more patients with various arthritic conditions—including peripheral rheumatoid arthritis, rheumatoid spondylitis, gout, periarthritis (painful shoulder syndrome), and osteoarthritis.

A thorough understanding of the pharmacology, therapeutic effects, and potential toxic hazards of phenylbutazone is imperatively required before trial of this potent agent. Hence, with the aim of extending knowledge of the background which is prerequisite to safety and optimal results with phenylbutazone therapy, we have made a detailed brief of the salient facts in the literature available up to this time.

CHEMICAL NATURE

In view of the established antiarthritic effectiveness of phenylbutazone, a compound not related to the steroid hormones, its chemical structure has basic interest in modern pharmacology.[5] It is the outstanding member of the pyrazolone group of compounds, many of which have antipyretic and analgesic properties.

As the following structural formula shows, phenylbutazone is 3, 5-dioxo-1, 2-dipheny 1-4-n-butyl pyrazolidine, —with two nitrogen atoms in the heterocyclic ring (not present in steroids):



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PHARMACOLOGY

In Experimental Animals

Synthesized in 1946 in a major program of pharmacologic screening of antipyretic and analgesic pyrazolone derivatives, phenylbutazone was found to have striking anti-inflammatory action in animals, in addition to definite antipyretic effect and a moderate capacity to raise the pain threshold.[5] Thus, phenylbutazone shows inhibition of (1) edema typically resulting from formalin injection, from erythematous exposure to ultra-violet rays, or from many other chemical or physical irritants, and (2) circumcorneal hyperemia normally a sequel to glycerin injection into the anterior chamber of the rabbit eye.[5]

In Human Beings

The exceptional anti-infiammatory action of phenylbutazone as shown experimentally led to extensive studies on its human pharmacology and therapeutic significance. The consensus is that oral administration of this drug does induce a therapeutically valuable anti- inflammatory action, most notably in arthritic disorders.[1-17] Confirmatory evidence from other areas of therapy includes demonstration of anti-inflammatory action in effecting the clinical resolution of superficial thrombophlebitis which had been refractory to other measures.[16]

Despite the obvious chemical dissimilarity, the number and nature of pharmacologic and antiarthritic similarities (table 1) between phenylbutazone and corticoids have inspired intensive analysis.[1] Thus far, it has been concluded that the anti-inflammatory and antiarthritic effects of phenylbutazone not only do not involve stimulation of corticoid secretion but, further, are not gained by or mediated through any hormonal instrumentality.[1, 5, 12] Unlike corticotropin (ACTH),

TABLE 1.—PHARMACOLOGIC AND ANTIARTHRITIC ATTRIBUTES OF PHENYLBUTAZONE AND CORTICOIDS
Similarities and Differences

Attribute	Phenylbutazone	Corticoids
Anti-inflammatory action	established experimentally and clinically	established experimentally and clinically
Antiarthritic effects	established in rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, gout, painful shoulder syndromes—therapeutic results in rheumatoid spondylitis and gout deemed generally superior to those obtained with corticoids	established clinically, but long-term results may be less satisfactory than those obtained with phenylbutazone
Analgesic action	distinct but moderate	absent, though relief of pain may ensue, from other action
Antipyretic action	distinct but moderate	secondary to other action
Effect on resistance to infection	no known effect	adverse effects are typical
Interference with normal processes of repair in rheumatoid arthritis	apparently far less marked than with corticoids or ACTH, as shown by long-term results	an outstanding deficiency of long-term administration of corticoids (and/or ACTH)
Tendency to upset hormonal balance	absent; no known effect on urinary 17-ketosteroids; no known effect on carbohydrate metabolism or insulin requirement	marked—causing many symptoms; depression of adrenocortical function; distinct tendency to increase insulin requirement; mental disturbances, etc.
Effects on electrolyte equilibria	causes retention of sodium, chloride, water; does not cause loss of potassium. **N.B.**: Retention of NaCl and H_2O is **not** cumulative as a rule—i. e., is typically self-limited	cause retention of sodium chloride, and water, with loss of potassium; retention of NaCl. and H_2O may be cumulative, and loss of K^+ serious
Propensity to reactivate or cause peptic ulcer	not as marked as in corticoid therapy	marked
Effect on elevated sedimentation rate	not consistent	may often reduce rate
Effect on elevated serum protein-polysaccharide ratio[12]	typically induces a fall	typically induces a fall
Effect on eosinophil count	no depression	depression

phenylbutazone does not cause a fall in adrenocortical ascorbic acid.

Absorption, Blood Levels, Biotransformation, Excretion

After oral administration, phenylbutazone is rapidly absorbed, the peak plasma level being attained usually within two hours.[1, 3, 5] Repeated doses produce a steady rise in plasma concentration until a limiting concentration is reached, after two or three days. Subsequently, plasma levels do not rise commensurately with increase in dosage. That is, a patient receiving the average initial dosage of 600 mg. daily will show a relatively slight rise in blood level of the drug even if the dosage is markedly increased.

The limiting plasma concentration, or "plateau" of plasma concentration attained with the accepted therapeutic dosage lies within the range of 60 to 150 mg. per liter. Varying from individual to individual largely because of differences in the rate of biotransformation, the plateau ("ceiling level") remains quite constant in the same patient.[1, 3, 5] Hence, dosage increase beyond the recommended maximum is not likely to bring increased benefits—but does tend to increase inordinately the risk of serious toxic reactions.

Biotransformation of phenylbutazone is comparatively slow; after withdrawal of the drug, detectable quantities are present in the body for 7 to 10 days or occasionally longer.[1, 3, 5] According to Brodie *et al.*: "It is probable that there is a marked increase in the rate of metabolic transformation at the elevated plasma levels which are achieved shortly after the administration of the drug."[1] And such acceleration of biotransformation may be a factor in the increased toxicity of the drug in high dosage.

Retention of Sodium Chloride and Water

Phenylbutazone causes an initial, limited retention of Na^+, Cl^- and water, as follows. Urinary volume and excretion of these ions decrease during the early phase of treatment, but usually return to pretreatment levels within 4 to 5 days. Meanwhile, a retention "pool" or excess of Na^+, Cl^-, and water has been accumulated to be retained generally without marked increase or decrease until discontinuance of the drug—when the excess of ions plus water is excreted.[1, 3, 5] Thus, ultimately, normal electrolyte equilibriums are restored. Potassium balance is not disturbed by phenylbutazone—in contrast to the action of cortical steroids and their congeners.

Increased Plasma Volume

Plasma volume is increased as a result of the retention of water during phenylbutazone administration. Consequently, the red cell count, hematocrit, and hemoglobin value are lowered in correspondence with the blood dilution.[9] Such decreases are progressive only during the first few days of treatment in accord with the water retention, which is limited in degree as noted in the

preceding section. As a rule, no reduction occurs in the packed red cell mass, hence hemodilution rather than a true anemia is demonstrated.[5, 9] The consensus is that phenylbutazone does not affect normal erythropoiesis or alter the rate of red cell destruction. A true anemia has been reported to occur in some patients receiving the drug.[9]

REPORTS FROM OTHER CLINICS

Nearly 300 reports on phenylbutazone have been published. It has been estimated that this drug has been prescribed to more than 3 million patients in this country alone. As regards therapy of arthritic disorders, the consensus may be summarized as follows:

THERAPEUTIC EFFECTIVENESS

Rheumatoid Arthritis (Peripheral)

When patients are carefully selected, conscientiously followed, and maintained on minimal dosage for control of symptoms, major improvement—often extending to remission—may be expected in somewhat more than 50 per cent of cases. Typically, when a favorable response is obtained, it is prompt—being apparent generally within 3 to 4 days after the start of phenylbutazone administration.[1, 2, 5, 9] Frequently, responsiveness may be in inverse ratio to the duration of the disease. If, after one week of phenylbutazone treatment, a worthwhile response is not evident, it is decidedly inadvisable to continue use of the drug.

Long-term results have been analyzed by Holbrook, in a comparative study of phenylbutazone, cortisone and ACTH, with the following conclusions: "The failure rate for phenylbutazone in peripheral rheumatoid arthritis, after the first six months, is less rapid than for cortisone and ACTH, but still fairly high. . . . It is obvious that none of these substances cures rheumatoid arthritis. They should be used only after establishing the patient on a comprehensive program and then with careful selection of patients."[6] As to selection of patients, Holbrook observed that "the acute, relatively early disease is the type least suitable for ACTH and cortisone . . . maximum suppressive doses will end in failure"[6] Today, phenylbutazone has a clearly established place in the over-all therapy of peripheral rheumatoid arthritis, always provided that the drug is used with adequate caution on wisely selected patients.[1, 2, 4–6, 8, 9, 11, 12, 14, 17]

Rheumatoid Spondylitis

The response of rheumatoid spondylitis to phenylbutazone is generally remarkable — apparently the great majority of patients show good or excellent improvement, which is usually sustained for months and years while administration of the drug is continued. In the long-term study of Holbrook it was concluded that: "Phenylbutazone shows a dramatically low failure rate in rheumatoid spondylitis."[6] Further: "In rheumatoid spondylitis, phenylbutazone is the drug of choice and to date the results have been much superior to those secured with x-ray therapy."[6]

Gouty Arthritis[1, 2, 4, 5, 7–10]

In gout, especially acute gouty arthritis, phenylbutazone has outstanding specific effects —most notably anti-inflammatory, uricosuric, and analgesic. The action is prompt, with subjective relief and objective improvement in acute gout being apparent usually within the first 24 hours of treatment with the drug. Acute attacks are typically controlled within a week, and the drug may be withdrawn. In chronic gout, phenylbutazone is often effective in keeping the patient free of pain and tends to decrease the frequency and severity of acute episodes. Each patient, however, must be carefully studied to determine individual response and tolerance. As a rule, only very low dosage in the order of 100 mg. daily is indicated in such therapy.

Other Arthritic Conditions

When due to subdeltoid bursitis, tendinitis and periarticular inflammation but not to trauma, the painful shoulder syndrome may respond to phenylbutazone in a relatively high percentage of cases.[5, 17] No significant effect, however, is to be expected as regards calcific deposits. In osteoarthritis, phenylbutazone may be of considerable value in alleviating spasm and pain but, of course, no retardation of the degenerative process can be achieved by any agent known today. In older patients, the use of phenylbutazone must indeed be circumspect, particularly in view of the possibility of the presence of cardiac conditions, moderate to severe hypertension, arteriosclerosis, and renal deficiency.

TOXIC REACTIONS

Like all other potent antiarthritic drugs, phenylbutazone has been found to produce side reactions in a considerable percentage of patients. Usually minor, such reactions to phenylbutazone may occasionally be serious, depending upon the care exercised in the selection of patients and in using the drug as well as upon individual susceptibility. Contraindications and precautions must be meticulously observed. (See below.) Dosage must be kept at a minimum, and the patient regularly examined.[1, 5, 9]

The over-all incidence of minor to severe side reactions to phenylbutazone appears to approximate 33 per cent, while reactions severe enough to necessitate cessation of treatment with this drug may occur in an estimated 12 per cent of patients.[9] The benefits must therefore be weighed against the toxic hazards, with phenylbutazone even as with all other potent antiarthritic agents.

Among the side reactions, edema is most frequent—a result of the tendency of phenylbutazone to cause retention of salt and water, particularly in older patients. Next in frequency is nausea—

often mitigated or prevented if the drug is taken just before or just after food; a sodium-free antacid may be of value. Relatively frequent also are epigastric pain, vertigo, central nervous system stimulation, visual symptoms, lethargy, constipation, and diarrhea. A true anemia may occur infrequently.[9]

Reactions severe enough to necessitate drug withdrawal are to be expected in some 12 per cent of cases, as follows (in order of decreasing frequency): Skin rash, stomatitis, reactivation or production of gastric ulcer, granulocytopenia, exfoliative dermatitis, and liver damage (a possibility which is still questionable).[9]

CONTRAINDICATIONS AND PRECAUTIONS[1-17]

Contraindications: (1) Edema, (2) cardiac decompensation, or possibility thereof, (3) peptic ulcer, or history suggesting it, (4) blood dyscrasia, or history thereof. And: (5) *No other potent drug should be used in conjunction with phenylbutazone. Such combined therapy inordinately increases the hazard of serious toxic reactions.*

Conditions necessitating utmost caution in use of drug:

(1) Hypertension, (2) cardiac conditions, (3) hepatic damage, (4) renal abnormality, (5) senescence, (6) history of drug sensitivity.

Special Precautions:

(1) Dosage in adults should be the minimum required to control symptoms, usually (a) initially, 400 to 600 mg. (rarely 800 mg.) in divided doses, daily, (b) first-week, therapeutic-test dosage should average 400 to 600 mg. daily and be adequate to determine response—and, if worthwhile response does not occur, the drug should be withdrawn at the end of the week; (c) minimal maintenance dosage to maintain improvement ranges from 100 to 400 mg. daily—and is determined by gradually decreasing initial "test" dosage to minimal effective level. Rarely, the maintenance dosage may necessarily be as high as 600 mg. daily, but it must be recognized that high dosage tends to cause an inordinate increase in toxic hazards.

(2) In rheumatoid arthritis and other chronic disorders, phenylbutazone may be indefinitely continued at the minimal effective level for control of symptoms and prevention of acute episodes.[1, 5, 9]

(3) **Close supervision of the patient is essential.** The patient should be impressed with the necessity of informing the physician immediately if any of the following symptoms are noted: Rash, fever, sore throat, oral lesions, black or tarry stools, edema. Regular examinations must be made and should include: (a) questioning and physical examination to rule out toxic reactions; (b) a weight check to detect significant retention of water; (c) complete blood counts—at weekly intervals during the early phase of treatment with the drug, and once every two weeks thereafter. Although rare, the possibility of granulocytopenia must be kept in mind. Any significant reduction in the formed elements of the blood must be regarded as calling for cessation of medication.

The occurrence of slight edema is not necessarily a signal to halt medication; this complication is often self-limiting and almost invariably subsides when the drug is withdrawn.[5, 9] Reduction of dosage may be followed by lessening or disappearance of ankle edema or edema of the face. Reduction of the dietary salt may have a similar effect. Nevertheless, the drug should be immediately withdrawn if clinical edema develops in patients with hypertension, cardiac difficulty, or renal dysfunction, or in an elderly patient.

Drug rash may subside when dosage is reduced. If the rash is severe or accompanied by fever, the degree of allergic reaction may be intense and call for cessation of medication. A marked idiosyncrasy to phenylbutazone may be encountered though rarely, the syndrome being similar to that of serum sickness; immediate and permanent withdrawal of the drug is then imperative. Stomatitis may or may not recur after phenylbutazone therapy is interrupted and begun again at a lower dosage; good oral hygiene may be helpful in preventing recurrence. The significance of such subjective sensations as vertigo and languor and other possible symptoms or side effects must be determined in relation to the degree of favorable response in the individual patient.

Finally, it must be stressed that: *Any significant fall in the total white blood cell count or a relative decrease in granulocytes is an imperative signal to halt medication at once and to institute the indicated counter-measures.* Routine blood counts cannot be dispensed with—and must be made at regular intervals, as previously noted.

CLINICAL OBSERVATIONS OF THE AUTHORS

Our use of phenylbutazone has been conservative, with the most careful regard for the details of selection, management, and close supervision of the patient, as set forth in our synopsis of the conclusions recorded by clinicians who have had extensive experience with phenylbutazone. The results obtained thus far are summarized below:

RESULTS*

Eight of 12 early cases of shoulder bursitis were immediately and permanently relieved.

Four cases of acute sciatica with no neurological or organic cause were relieved immediately.

Used extensively in rheumatic arthritis with

*Since this report was written we have administered phenylbutazone for two cases of superficial thrombophlebitis, one primary and one secondary, with immediate relief of symptoms.

prompt relief in more than 50 per cent of cases treated (42)—many extending to remission.

Many cases of osteoarthritis treated with relief of pain and spasm and patients remained comfortable with small maintenance dose.

In many of these cases we now consider phenylbutazone the drug of choice, especially in the acute phase.

DISCUSSION

Although some earlier reports dealt pointedly with toxic reactions to phenylbutazone, such emphasis has been valuable indeed, because: (1) The potential hazards have been clarified and justifiably stressed, if at times over-stressed; (2) The relationship of toxicity to high dosage has been set forth; (3) The contraindications and precautions to be meticulously observed have been evolved for the maximal safety and comfort of the patient; (4) Leading clinicians with extensive experiences in the use of phenylbutazone have been stimulated to present their observations and evaluations, so that phenylbutazone has been established as an outstanding therapeutic aid in the over-all management of patients having peripheral rheumatoid arthritis, rheumatoid spondylitis, gout, and certain types of periarthritis.

In general, our results have been decidedly worthwhile and often quite gratifying to both patient and physician. When side reactions of corticosteroids and ACTH are considered, especially with respect to the disappointingly high percentage of early or late relapses, the long-term results with phenylbutazone therapy must be deemed superior in many patients.

It must be concluded that phenylbutazone has definitely anti-inflammatory efficacy as well as other specific antiarthritic effects in human arthritides, as evidenced by: (1) The excellent results in long-term therapy of rheumatoid spondylitis; (2) Marked improvement in more than 50 per cent of patients with peripheral rheumatoid arthritis; (3) Remarkable remissions in at least a small percentage of patients with peripheral rheumatoid arthritis—improvement which must be designated as Grade I in accord with the criteria of the American Rheumatism Association; (4) The strikingly prompt remissions obtained in gouty arthritis; and (5) Frequently excellent responses in periarthritis (especially nontraumatic subdeltoid bursitis, tendinitis and associated periarticular inflammation).

In our judgment, phenylbutazone represents an outstandingly valuable addition to the weaponry available against arthritides.

SUMMARY AND CONCLUSIONS

1. In a conservative trial of phenylbutazone as an antiarthritic agent in the over-all management of the patient, decidedly worthwhile results have been obtained in peripheral rheumatoid arthritis and periarthritis (painful shoulder syndrome, nontraumatic, with bursitis and tendinitis).

2. Improvement was often impressive in rheumatoid spondylitis, the favorable response generally being well sustained as medication was continued.

3. In acute gout, phenylbutazone may be the agent of choice in most patients.

4. With the most careful regard for the details of selection and close supervision of patients, the physician can utilize phenylbutazone to significant advantage as an antiarthritic drug of proved, often outstanding efficacy.

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Application of Radioisotopes To Clinical Diagnosis

Radioisotopes, originally applied only to experimental problems in hematology, now have wide application to clinical diagnosis. The two most widely used technics employ Cobalt-60 labeled vitamin B_{12} and Chromium-51 labeled red cells. The Cobalt-60 vitamin B_{12} absorption study is an indirect measure of intrinsic factor activity in the stomach while the labeling of red cells with Chromium-51 provide an index of the length of survival of circulating erythrocytes. These tests provide a means by which the dynamics of certain disease processes may be simply and accurately determined.—William L. Hughes, B. S., et al., Oklahoma City: *Southern M. J.*, 50:709, June, 1957.

Surgical Correction of Deafness

WILLIAM H. SAUNDERS, M. D.

HEARING may be restored by several different surgical procedures. Certain operations are performed on the ear itself; others correct deafness by treating adjacent regions. Some of these operations have been used successfully for many years. Others are new and have captured the imagination of physicians and laymen alike because of their ingenuity and effectiveness.

After briefly reviewing the mechanics of hearing, I will explain how to distinguish between operable and nonoperable deaf patients and will describe the more common surgical operations for relieving deafness.

TYPES OF DEAFNESS

There are two general groups of deaf patients, those with conductive deafness and those with nerve deafness. Only patients with conductive deafness are suitable candidates for restoration of hearing by surgical methods.

Aldous Huxley has neatly summarized the mechanics of the middle ear in this paragraph:

> ". . . the scraping of the anonymous fiddlers had shaken the air in Lord Edward's apartment on the further side. The shaking air rattled Lord Edward's membrana tympani; the interlocked malleus, incus, and stirrup bones were set in motion so as to agitate the membrane of the oval window and raise an infinitesimal storm in the fluid of the labyrinth. The hairy endings of the auditory nerve shuddered like weeds in a rough sea; a vast number of obscure miracles were performed in the brain and Lord Edward ecstatically whispered, 'Bach!' "[1]

In the patient with conductive deafness, the "shaking air" is impeded somewhere along its course as it traverses the external auditory canal and the middle ear. It fails to rattle the drumhead and the ossicles and does not vibrate the stapes in the oval window. Therefore, the hairy endings of the auditory nerve do not shudder at all, or they shudder only slightly. The patient has no sensation of sound, or he hears sound at a reduced loudness.

In the patient with nerve deafness, sound reaches the hair cells of the auditory nerve with normal intensity; but because of damage to the hair cells themselves or because of damage to the nerve fibers, the patient cannot hear normally.

THE PHYSICAL EXAMINATION

It is important to be able to distinguish between conductive deafness and nerve deafness. This distinction is made in several ways. Usually the eardrum of the patient with nerve deafness is normal because his deafness is due to disease within or central to the cochlea and has nothing to do with the external ear or middle ear. Any changes in the eardrum are incidental to the nerve deafness. Examination of the patient with conductive deafness will show (except in otosclerosis) the cause for the impedance to the sound waves. Either there is no ear canal, the ear canal is blocked, the drumhead is perforated, or some other visible manifestation points directly to the disease condition.

THE FUNCTIONAL EXAMINATION

More important than physical examination in distinguishing between conductive deafness and nerve deafness is functional testing of the ear—in other words, examining the patient's hearing.

Because patients with conductive deafness merely have to overcome a mechanical impedance in order to hear, they hear very well if the sound intensity is raised sufficiently. Their hearing may be likened to that of a person far from the speaker. The listener could hear perfectly if only the speaker would speak more loudly or use an amplifying system.

On the other hand, patients with nerve deafness may be unable to understand or differentiate elements of the sound they hear even when the speaker talks loud enough to make them hear. The result is that many such patients have difficulty understanding speech. It is characteristic of the patient with nerve deafness to remark, "I can hear you but I can't understand what you are saying." One may demonstrate this inability to discriminate speech sounds by asking a patient to repeat phonetically similar words, such as "sin," "fin," and "thin." Frequently the patient with nerve deafness cannot distinguish between such words, whereas the normal person or the person with conductive deafness will have little difficulty provided only that sound intensity is adequate.

Increasing the intensity of sound to the nerve deafened ear may have no appreciable effect in increasing the ability to discriminate. In fact, intelligibility may be lowered still more if the sound becomes too loud. Thus the patient with

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nerve deafness generally is not so good a candidate for successful use of a hearing aid as one with conductive deafness because even though a hearing aid makes words audible it cannot make them intelligble. Discrimination of sound seems to be a special function of the sensory endings of the auditory nerve. Therefore, when these cells are intact, as they are in conductive deafness, a mere increase in loudness affords good understanding of speech. The opposite is true in the type of nerve deafness in which the sensory hair cells are injured. Fortunately, not all patients with nerve deafness have injury to the sensory hair cells, and many patients with nerve deafness use hearing aids satisfactorily.

A practical point to remember in distinguishing between conductive deafness and nerve deafness is that patients with conductive deafness are never totally deaf. Their deafness varies from very slight loss to a loss of 60-70 decibels. Even with a maximum conductive loss of 70 decibels, a loud voice is still audible. Nerve deafness, on the other hand, may be complete—although it seldom is.

How well patients discriminate is measured with a speech audiometer and a special list of recorded words. Common one-syllable words are presented to the patient at optimal intensity through earphones, and the patient repeats what he hears. A poor score indicates that his deafness is likely due to disease of the hair cells. He is not expected to benefit greatly from a hearing aid.

Also of great importance in testing hearing and in distinguishing between conductive and nerve deafness are the pure tone audiometer and tuning forks. Pure tone audiometry as well as speech audiometry is rather technical, and generally these methods are not employed by the general practitioner. However, the use of tuning forks is extremely practical and should be mastered by every physician who would examine or advise patients regarding deafness.

TUNING FORK TESTS

The Rinne test is performed by alternately placing a ringing tuning fork opposite one external auditory meatus and then applying it to the adjacent mastoid bone. The normal ear hears a tuning fork about twice as long by air conduction as by bone conduction. In well developed conductive deafness, this normal ratio is reversed. The patient hears just as long by bone conduction as by air conduction, or he may actually hear longer by bone conduction than by air conduction. Patients with nerve deafness, on the other hand, hear much better by air conduction than by bone conduction, and they maintain the normal ratio.

The Weber test is performed by placing a ringing fork on the upper incisor teeth or on the midline of the skull. The patient with normal hearing reports that he hears the fork ringing in both ears or that it seems to ring somewhere in the middle of his head. In unilateral conductive deafness, the patient hears the fork in the poorer ear. In a patient with unilateral nerve deafness, the sound is lateralized to the good ear.

Common Mistakes: Here are some of the common mistakes in using tuning forks:

1. Striking the fork too hard. A tuning fork is best vibrated by stroking it between the index finger and thumb. This produces a sound which is free of overtones and is not likely to be excessively loud.

2. Holding the fork obliquely rather than with the tines directed at the ear. If the tines of the fork are directed at the ear obliquely, there could theoretically be no sound at all because of a cancellation effect. Hold a tuning fork to your own ear and rotate it slowly. You will note that the tone increases and diminishes in intensity depending upon the position of the tines with respect to the external auditory meatus.

3. Improperly applying the fork to the mastoid bone. Intermittent pressure enables the patient to perceive sound more readily than constant pressure. Not all parts of the mastoid are equally satisfactory to use for bone conduction. In general, the region just above and behind the external meatus (antral area) is best.

SURGICAL TREATMENTS FOR DEAFNESS

Before describing certain operations and other manipulative procedures to relieve deafness, I will emphasize two prerequisites for operation.

First, the patient must be deaf in both ears to warrant major surgery. If he has serviceable hearing in one ear, a major operation ordinarily is not indicated since monaural hearing is almost as acute as binaural hearing (except for loss of directional sense). For the same reason, persons with one normal ear are not advised to use a hearing aid in the poor ear. Serviceable hearing is usually considered as hearing which is not worse than 30 decibels loss in the speech frequencies (500 to 2,000 cycles per second).

Second, hearing loss must be due to conductive deafness.

I. OTOSCLEROSIS

Otosclerosis is a disease which affects the temporal bone and which sometimes causes conductive deafness. Not all persons with otosclerotic foci in the temporal bone become deaf. To produce deafness, otosclerosis must attack the region of the oval window and immobilize the footplate of the stapes.

The cause of otosclerosis is unknown. It is chiefly a disease of young women although men are also affected. It is familial. The onset is insidious, and patients are often unaware of their deafness for several years. Then at the age of 20 or 25 years they may seek medical advice because of bilateral progressive deafness. Later in the course of the disease, patients sometimes

acquire superimposed nerve deafness, but the classical case is one of pure conductive deafness.

Fenestration operation. About 20 years ago, an ingenious one stage operation for otosclerosis was perfected. A new window (fenestra) into the labyrinth is created so that sound pressure can enter and leave the cochlea and thereby stimulate hair cells in the organ of Corti. This procedure is known as the fenestration operation.

Through the so-called endaural approach, a partial mastoidectomy is done. A small opening made in the dense bone of the horizontal semicircular canal exposes the perilymph of the labyrinth. The skin of the posterior wall of the ear canal is meticulously preserved and left attached to the drumhead. This skin is used to seal the newly created fenestra. As a result of this operation, hearing may be restored to practical levels, although it cannot be restored to normal. The operation is very successful when used on otosclerotic patients without nerve deafness. Eighty per cent of patients operated upon have good hearing at the end of five years.

Stapes mobilization. A more recent operation for otosclerosis is known as the stapes mobilization procedure. Actually this technique is older than the fenestration operation, since it was attempted more than 50 years ago. Earlier efforts were largely unsuccessful, and until recently the procedure was forgotten or in disrepute.

In 1952 the mechanical loosening of the stapedial footplate was again suggested as a way of restoring practical hearing to otosclerotic patients. In the last few years thousands of stapes mobilization procedures have been done.

The technique, performed under local anesthesia, is simpler than that of the fenestration operation. An incision is made in the skin of the ear canal near the drumhead, and the annulus of the drumhead elevated out of the tympanic ring. As a result, the drumhead can be reflected from its peripheral attachment. The stapes is exposed. Using special instruments and working under magnification, the operator makes pressure on the stapes in an endeavor to rock the footplate free of its otosclerotic bindings. Audiometric testing at the time of the operation enables the surgeon to determine the hearing gain at any stage of the operation. After manipulation of the stapes, the drumhead is returned to its original position. The patient leaves the hospital in two or three days.

Results are not as uniformly satisfactory with the stapes mobilization technique as with the fenestration operation. Also, the procedure is so recent that long term results cannot be evaluated now. At present, many operators employ the stapes mobilization technique in otosclerotic patients who have superimposed nerve deafness or in patients regarded as having early otosclerosis; in either instance, the patient is unsuitable for the fenestration operation. Theoretically, the stapes mobilization technique can improve hearing more than the fenestration operation, because in the fenestration operation the ossicular chain is interrupted by removing the incus.

II. ADENOIDECTOMY

Of all surgical precedures designed to restore and maintain hearing, the adenoidectomy is the most common. In the infant and child, and occasionally in the adult, adenoids may obstruct the eustachian tube and cause conductive deafness by impairing physiologic mechanisms of the middle ear.

Somewhat oversimplified, the following chain of events occurs when adenoids obstruct the eustachian tube. Air in the middle ear and mastoid cannot be normally replenished every time the patient swallows, and some of the air in the middle ear is absorbed into the blood stream. The result is a partial vacuum in the ear. The negative pressure causes a sterile transudate of blood serum to fill or partially fill the middle ear. The resultant picture as viewed through the ear speculum is a retracted, yellow or amber eardrum. Frequently both air and fluid are present in the middle ear, and careful scrutiny discloses an air-fluid level seen as a dark hairline extending across the eardrum; or the air may collect in pockets and be seen as bubbles in the serum. This last condition is called serous otitis media.

If the patient is a child, often there is no complaint except that the mother may say that the child doesn't pay attention or, if she is a good observer, that he is hard of hearing. Children with serous otitis are usually deaf only intermittently. They become deaf when they have a cold or when allergic manifestations are present. Their deafness is never complete; usually it is only mild or moderately severe. Of course, if serous otitis occurs in one ear only, the parents entirely overlook the condition since the child hears satisfactorily with the normal ear.

The intermittent nature of serous otitis may be the source of considerable confusion among the school teacher, the parents, and the doctor. For example, an audiogram taken in school in March may show a 40 decibel hearing loss in one or both ears. By the time the child is examined by a doctor in April, the hearing has returned and the eardrums appear normal. Unless the doctor is aware of the reversible mechanism responsible for serous otitis, he may question the accuracy of a perfectly good audiogram.

The adenoidectomy operation is performed under general anesthesia with or without an intratracheal tube. Of course importance is meticulous removal of adenoid tissue from the region of the eustachian tube. It is this laterally placed lymphoid tissue which causes deafness, and not the central mass of adenoids so commonly removed with the adenotome and a few desultory sweeps of the curette. The careful operator will place a folded blanket under the patient's shoulders

to allow extension of the head. He then retracts the soft palate and visualizes the nasopharynx. Careful trimming of adenoid tissue from all sides of the eustachian tube is done with special adenoid punch forceps until all visible and palpable adenoid tissue is removed. Such a technique engrosses a careful operator for as long as a half hour, although a less discreet operation may be completed in one or two minutes.

After removal of the adenoids, the eustachian tubes can again ventilate the middle ear and the serous otitis resolves. Some operators perform a paracentesis of the fluid-filled middle ear at the time of adenoidectomy and suck against the paracentesis opening with a small middle ear sucker. They recover serum or a thick glue-like substance, the consistency of which makes one wonder how the patient would ever have disposed of the tenacious material naturally.

The doctor should be careful to warn the parents of the allergic child that adenoids may recur and have to be removed again. In most otherwise normal children, a carefully performed adenoidectomy is a definitive operation and need not be repeated. Ordinarily the faucial tonsils are removed at the same time as the adenoids, although the tonsils have a negligible effect and the adenoids a maximal effect on hearing.

III. CHRONIC OTITIS MEDIA

Chronic otitis media and chronic mastoiditis are largely synonomous. The patient who has uncomplicated chronic otitis media complains of just two symptoms: discharge and hearing loss. He should not complain of headaches. If he does develop head pain or dizziness, it usually indicates the onset of a complication or superimposed acute infection.

The deafness associated with chronic mastoiditis may be due to several causes, including perforation of the eardrum and destruction of ossicles in the middle ear. In long-standing cases, nerve deafness is found in addition to the original conductive deafness. Patients with both kinds of deafness have a mixed type of hearing loss, so-called because it is partly a conductive loss, partly a nerve loss.

Surgical restoration of hearing in patients with chronic mastoiditis is less successful than in any of the diseases previously discussed. The operator may improve hearing in an occasional patient by removing diseased tissue from the middle ear or mastoid so that drainage improves and the drumhead can heal. But often the perforated drumhead does not heal, and even though the drainage may cease, hearing is not appreciably improved.

IV. CLOSING PERFORATED EARDRUM

Closing a tympanic perforation is a procedure which has stirred the imagination of many. Although possible and occasionally successful, closing tympanic perforations is an operation which frequently disappoints both doctor and patient.

Repeated freshening of the edges of the perforation with a paracentesis knife and then laying a piece of cigarette paper across the drumhead is an old method. More recently, the use of amniotic membrane for this purpose has been suggested. In another procedure, a skin graft is placed against the eardrum, which has been previously slit radially from the perforation. The skin graft and the freshly cut flaps of the drumhead close the perforation by adhering to the medial wall of the middle ear.

There is some danger that treatments designed to close a tympanic perforation may cause infection or that for some other reason the treatment may become worse than the disease.

V. EUSTACHIAN CATHETERIZATION

Eustachian catheterization, a standard otologic procedure for office use, is designed either to test or to establish patency of the eustachian tube. Because it requires instrumentation, it is described here as a surgical technique. A metal catheter with a suitably curved beak is passed through the previously anesthetized nose. The beak of the catheter is brought to rest in the pharyngeal orifice of the eustachian tube. Then air is blown into the catheter, and the physician determines if the eustachian tube is patent by listening with a stethoscope held in the patient's ear.

A normal person can inflate his own middle ear by holding the nose and swallowing. The effect of this modified Valsalva's experiment is easily determined by observing the eardrum. If the eardrum moves when the patient swallows, the eustachian tube is patent. A reliable patient can be trusted to report if he feels his ear fill up with pressure at the moment of the reinforced swallow. This procedure effectively demonstrates patency of the eustachian tube, and catheterization for this purpose becomes unnecessary.

For restoring hearing, eustachian tube inflation must be used in patients with conductive deafness, which, of course, must be due to eustachian tube obstruction and not otosclerosis. Some patients with nerve deafness are needlessly subjected to eustachian tube inflations.

VI. CONGENITAL ATRESIA OF THE EXTERNAL EAR CANAL

Congenital atresia of the external auditory canal is uncommon. Sometimes it is associated with microtia, and sometimes the auricle is normal. The atresia may be bilateral or unilateral. When it is unilateral, the normal ear has good hearing, and no operation is done to correct the atretic canal. However, if the condition is bilateral, an operation for reconstruction of one external auditory canal is advised.

Surgical correction of an atretic ear canal is a difficult operation and involves channeling an ear

canal through mastoid bone. Sometimes the contents of the middle ear are normal, but often the malleus and incus are malformed so that hearing is still not normal even though a new ear canal is created. A fenestration procedure is performed in some instances to improve hearing additionally. Skin grafting of the newly formed ear canal maintains its patency.

VII. CERUMEN REMOVAL

The mechanical removal of cerumen and other particulate matter from the external auditory canal is a manipulative procedure practiced by every physician at one time or another. The commonest obstruction to the passage of sound waves through the ear canal is by cerumen itself, but also important are foreign bodies, aural polyps, osteomata, and the debris formed by desquamation of squamous epithelium.

Cerumen is removed by irrigation or by using a cerumen spoon or cotton tipped applicator. Soft cerumen is easily removed by irrigation with tap water. It is very important that the water be approximately at body temperature; otherwise the patient may become dizzy due to stimulation of the labyrinth by water which is too warm or too cold.

I have never seen an eardrum injured as a result of excessive pressure in irrigation, although conceivably such injury could occur. Contrary to general opinion, it is also very unusual to see an eardrum injured by a patient who cleans the ear with a toothpick or hairpin. The skin of the bony ear canal adjacent to the drumhead is exquisitely sensitive and very easily contused. This part of the ear canal is frequently injured, with resultant pain and bleeding, but the drumhead itself is made of tougher stuff and tends to resist traumatic perforation.

Hearing is not diminished by cerumen accumulation until the ear canal is completely occluded. Often a casual examination leads the doctor to believe the ear canal is completely blocked with wax, but a closer look will disclose a channel (often superiorly) through which air reaches the drumhead. It is important to visualize this slit of free airway, because it is here that the irrigating stream should be directed or the cerumen spoon inserted. To remove cerumen mechanically, one should introduce the cerumen spoon behind the entire mass of wax and pull it forward. This is a better method than picking small pieces off the mass of wax.

Other types of particulate matter are removed similarly; the technique varies with the situation. Special forceps for grasping foreign bodies are available for use through an ear speculum under direct visualization.

Finally, I wish to emphasize that all manipulations in the external ear canal and the middle ear should be performed under direct visualization. This demands the use of a good light source. In my opinion, the best light is obtained by using a 150 watt light bulb and the otologist's headmirror. The electric otoscope is a good diagnostic instrument, but when used to provide light for surgical manipulations, the otoscope is cumbersome and unwieldly.

SUMMARY

Deaf patients are unable to hear either because of injury to the nerve of hearing or because of a mechanical impedance to sound waves traversing the external auditory canal and the middle ear.

Certain surgical procedures will restore hearing in patients with conductive deafness. Hearing cannot be restored by surgical means in patients with nerve deafness. Therefore, it is important to be able to distinguish between nerve deafness and conductive deafness, and the customary methods of making this distinction are described.

Several operative and manipulative procedures which can restore hearing are described. These include two operations for otosclerosis, adenoidectomy, treatment of chronic otitis media, closure of the perforated eardrum, eustachian catheterization, repair of congenital atresia of the external auditory canal, and removal of cerumen.

REFERENCE

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Secondary Infections May Occur Following Antibiotic Therapy

Ever mindful of the dictum—*primum non nocere*—it is mandatory that clinicians be aware of the fact that with the administration of antibiotic drugs, resistant and insensitive superinfections of fungus and bacterial origin may occur. These complications may be more serious than the original condition.

There is a group of individuals in whom secondary infections may occur when given antibiotics:

1. The geriatric patient in whom bodily processes and immune responses are likely to be at low ebb and who in all probability is avitaminotic.

2. The premature and young infant in whom susceptibility to numerous infections is common because of lowered resistance and undeveloped antibodies.

3. The diabetic in whom because of disturbed metabolic functions cutaneous and vaginal moniliasis occur frequently.

4. The pregnant female in whom disturbance of the normal vaginal physiology increases the incidence of fungus infections.—Walter Kohn, M. D., Baltimore, Md.: *Maryland State M. J.*, 6:254, May, 1957.

Diabetes and Tuberculosis*

W. L. WALLBANK, M. D.

PHYSICIANS have long known that the incidence of tuberculosis is higher in diabetic patients than in the general population. There is also a strong impression and some scientific evidence to suggest that tuberculosis is more rapidly progressive and difficult to control in the diabetic than in the non-diabetic patient.

In the Philadelphia survey of 1946, the incidence of tuberculosis in 3,106 diabetics was found to be 8.4 per cent. In contrast the incidence in non-diabetic individuals was reported at 4.3 per cent. More important, tuberculosis was found to be active in 2.6 per cent of diabetics surveyed—three times the percentage of active tuberculosis found in non-diabetic individuals. In diabetics under 40 years of age 5.3 per cent were found to have active tuberculosis.

Four to five per cent of tuberculous patients under treatment in sanatoria are diabetic. It is generally conceded that diabetes does not develop more frequently in patients already having tuberculosis than it does in the non-tuberculous.

The symptoms of tuberculosis occurring in the diabetic patient are fundamentally no different than in the non-diabetic. In the early stages symptoms may be absent. In the presence of active tuberculosis, diabetes may become more difficult to control and the insulin requirement increased. When the tuberculous disease has become inactive, the insulin requirement returns to an amount similar to that present before the onset of tuberculosis.

IMPORTANCE OF PREVENTION AND EARLY DETECTION

Because of the high incidence of tuberculosis in diabetic patients, all diabetics should receive frequent chest x-ray examinations, preferably at six month intervals. Diabetics known to have been exposed to tuberculosis should be x-rayed at more frequent intervals.

The prevention of tuberculosis in diabetics is most important. Exposure to known cases of tuberculosis should be carefully avoided. Tuberculosis is known to occur more frequently in diabetics who are underweight. In the case of diabetics who must reduce, weight loss should be gradual. The patient should be followed carefully by frequent chest x-ray examinations during the process. In the case of juvenile diabetics who become tuberculin positive there is a strong indication for vigorous treatment using oral drug therapy consisting of INH® (isoniazid) alone, or preferably INH® and PAS (para-aminosalicylic acid) combined.

*This is one of a series of articles on chest diseases sponsored by the Ohio Trudeau Society, medical section of the Ohio Tuberculosis and Health Association.

Submitted May 1, 1957.

The Author

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TREATMENT MUST BE ENERGETIC

Although tuberculosis is known to progress rapidly and show a high mortality in the case of poorly controlled or uncontrolled diabetes, energetic treatment of the tuberculosis combined with good control of the diabetes will give a result which will approximate that obtained in the non-diabetic. It is regrettable that tuberculosis is often found in the advanced stage in diabetics. Patients suffering from advanced tuberculosis will naturally present a difficult problem from the standpoint of control of their diabetes. Appetite is poor and the patient is toxemic. In such cases regular insulin will often be necessary until both the diabetes and tuberculosis have improved. Change to longer acting insulin may be made as soon as practicable. Insulin dosage is changed gradually and insulin shock carefully avoided because of the danger of aspiration of tuberculous sputum into uninvolved areas of lung during periods of unconsciousness.

If normal or overweight, the patient's weight should be maintained until such time as his tuberculosis has been well controlled. If reduction is necessary because of marked obesity or because of the cardiovascular status, reduction should be slow and very carefully observed. However, most patients with advanced tuberculosis in the presence of diabetes will be found to be underweight, and it is necessary that a relatively high calorie diet be prescribed with sufficient insulin to increase the weight to normal. Patients with active tuberculosis are known to have a deficiency of protein and vitamins A and C. It is therefore well to provide somewhat more than the usual amount of protein. A high vitamin intake is important.

STANDARD ANTI-TB DRUG THERAPY

Modern drug therapy for tuberculosis has greatly improved the lot of the tuberculous diabetic. Although differences of opinion exist concerning the best drug therapy, any of the three

commonly used combinations of drugs may be used. INH® and PAS given by mouth in the usual dosages will usually give excellent results. In advanced and very ill cases, however, many workers believe that all three drugs, streptomycin, INH® and PAS are indicated. These drugs have no effect on the diabetes itself, except as a result of improvement of the tuberculosis.

Surgery when indicated should be performed without hesitation in the well controlled diabetic patient. It is necessary, however, that the patient be carefully prepared for surgery and that he be followed very carefully postoperatively. Resection of dangerous residual lesions where possible is important in young diabetics if they are to remain permanently well.

Although the outlook for the patient who suffers from both diabetes and tuberculosis has been regarded as exceedingly gloomy in the past, it is our feeling that under modern treatment of both diseases, the prognosis is favorable. Insofar as tuberculosis alone is concerned, the results in carefully controlled diabetics are almost as favorable as those in the non-diabetic.

Indications for Androgenic Therapy of Woman

There is clinical need for anabolic steroids, which are devoid of androgenic, estrogenic, progestational or other undesired side activity. None is available at present. Methyltestosterone and testosterone propionate, relatively short-acting and relatively rapidly-eliminated androgens, are judged to be the best suited currently available androgens for the treatment of woman. Their use should be founded upon a definite and logical indication. Their empiric use is condemned.

The most general indication for androgenic therapy of woman is based upon the desirability of the anabolic action of androgens on protein and osseous tissues. Estrogenic therapy may provide similar action and estrogens should be used when feasible and when they provide adequate anabolic effects. Otherwise combined androgen-estrogen therapy is indicated.

Careful supervision of the androgen-treated woman should be maintained, and treatment should be discontinued at the earliest sign of any virilization, unless the benefit of this therapy justifies the price of virilization.

The palliative use of androgens in the treatment of selected patients with metastatic carcinoma of the breast appears justified, although improvement is only temporary and often short-lived, despite the fact that doses which produce virilization are required.

A trial of conservative treatment with low doses of methyltestosterone in endometriosis appears warranted.—E. C. Hamblem, M. D., Durham, N. C.: *Southern M. J.*, 50:743, June, 1957.

Franklin County Pelvic Cancer Delay Committee Report

By John H. Holzaepfel, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met at the Columbus Health Center on Wednesday, June 26, 1957, at 12:00 noon. The following cases were presented:

Case No. 1: A 34 year old white female who had had a subtotal hysterectomy eight years prior for a "cyst," entered the hospital with history of intermittent vaginal spotting for 10 months. Consulted physician and papanicolaou smear was done which showed tumor cells. The day following admission to the hospital an abdominal trachelectomy was done. Pathology report revealed a diagnosis of leukoplakia and early carcinoma of the uterine cervix.

Comments: *Patient delay* of 10 months. *Physician delay* of eight (8) years.

Case No. 2: A 49 year old white female who had intermittent intermenstrual bleeding for two years and post-coital bleeding for six months. She consulted physician when vaginal bleeding became profuse—two days prior to hospital admission. Examination revealed induration into the left vaginal fornix which extended to parametrium and to the left pelvic wall. Also had an ulcer covering the entire left fornix. Frozen section of the cervix revealed carcinoma of the cervix, Clinical Stage III.

The patient was treated with external therapy and radium.

Comments: *Patient delay* of two years.

Case No. 3: A 67 year old white female whose case had been diagnosed as carcinoma of the cervix four months prior to admission to the hospital. At that time she received radium. There was evidence of persistence of carcinoma at the external os. The day following her second hospital admission, the patient had a total (abdominal) hysterectomy, bilateral salpingo-oophorectomy. Pathology report revealed evidence still of invasive carcinoma of the cervix.

Comments: Hysterectomy done in the presence of extensive carcinoma.

Factors Involved in Mortality of Acute Myocardial Infarction

We have presented a study of the factors involved in the immediate deaths of 154 patients with acute myocardial infarction occurring in a general hospital.

Factors having a direct bearing on mortality, as shown by this review, are (1) age of the patient; (2) diabetes mellitus; (3) obesity; (4) previous myocardial infarction; (5) the development of serious arrhythmias; (6) shock; (7) congestive heart failure; and (8) coexisting major diseases.

The mortality was considerably higher in women. In this series, the anticoagulant-treated group had a lower mortality than the non-treated group. This difference could not be attributed to the presence or absence of thromboembolic processes.—Ellsworth L. Lindley, M. D., and Ben F. Wolverton, M. D., Cedar Rapids: *J. Iowa M. Soc.*, 47-311, June, 1957.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Ralph J. Johansmann, M. D., President

Presented by Richard W. Zollinger, M. D., and Emmerich von Haam, M. D. Edited by Dr. von Haam

PRESENTATION OF CASE

THE patient was a 73 year old white male admitted because of persistent nausea and vomiting. Nine months prior to this last admission he had a left colectomy and mesenteric lymph node dissection with an end-to-end Baker type anastomosis of the transverse colon to the rectum for a well-differentiated polypoid adenocarcinoma of the rectum. A transurethral prostatic resection for benign hypertrophy was also performed later during this admission. He was discharged with good bladder and rectal function.

Two months before his last admission he noted a dull right upper quadrant pain radiating around into the back. His stools had become loose lately, requiring paregoric for relief. A barium enema done on an outpatient basis one month before was normal. Four days before admission he had attacks of nausea and vomiting after meals with increasing tenderness of the right upper abdomen. There was no history of jaundice or hematemesis. The day of admission his abdomen became distended.

PHYSICAL EXAMINATION

Blood pressure was 112/68, pulse 90 and regular, respirations 14, temperature 102°F. rectally. The patient was well developed but emaciated. The head, eyes, ears, nose and throat were normal. He had pitting edema of his left forearm and of the right leg. The chest was clear. The heart had no murmurs, rate was regular, pulse bounding.

The liver was palpated 5 to 6 fingerbreadths below the costal margin and was smooth and firm but questionably tender. The left lower quadrant showed a fluctuant oblong mass with dullness. Bowel sounds were diminished in intensity. The skin was dehydrated. Rectal examination was not done on admission, but a sigmoidoscopy three weeks before admission was reported negative.

Submitted May 21, 1957.

ROENTGENOGRAPHIC EXAMINATION

The heart and lung films were negative. A plain film of the abdomen showed air in the cecum with a few distended small bowel loops in the right upper quadrant. There seemed to be a soft tissue mass within the pelvis compressing the medial aspect of the cecum. An increased density along the left side of the abdomen was interpreted as colon distended with feces. The liver was enlarged.

Barium enema showed the right and left colon to be displaced laterally by a large soft tissue density in the lower mid-abdomen and pelvis, producing external pressure on the colon and depressing the sigmoid. The end-to-side anterior anastomosis was noted and there was no obstruction or filling defect within the colon. Films of the abdomen taken at 2, 3, 5, 12, and 24 hours after a barium meal showed normal passage of the barium through the small gut without obstruction. The 12-hour film showed scattered diverticula in the transverse colon.

LABORATORY DATA

The white blood cell count was 32,700 with 27 per cent segmented neutrophils, 55 per cent nonsegmented, 15 per cent lymphocytes, 2 per cent eosinophils, 1 per cent monocytes; red blood cell count was 5.14 mil.; hemoglobin 15.4 gm. Serum sodium was 140, potassium 2.3; chlorides 102 mEq.; the CO_2 combining power was 56.5 vol.; the total protein was 7.1 gm. with 4.4 gm. of albumin and 2.7 gm. globulin; bromsulphalein test showed 30 per cent retention; cephalin flocculation test showed a trace. His blood urea nitrogen was 104 mg. His urine examination

showed a specific gravity of 1.025, a *p*H of 5.5 and 10 to 15 white blood cells and 3 to 5 red blood cells per high power field.

Repeat tests showed a white blood count of 40,000 with 68 per cent segmented neutrophils, 20 per cent nonsegmented, 10 per cent lymphocytes, 2 per cent monocytes; hemoglobin 13.6 gm.; red blood count 4.54 mil. The sodium was 147, potassium 3.9 and chlorides 105.5 mEq. Blood urea nitrogen was 64 mg. Electrocardiogram showed auricular flutter with 2 to 1 block.

HOSPITAL COURSE

The patient was given intravenous fluids and electrolytes (sodium chloride, potassium chloride), 500 cc. of whole blood the first day, penicillin, and demerol® for pain. His urinary output averaged 800 cc. per day throughout. A Levin tube was inserted on the second day and 3700 cc. of "dirty, foul-smelling material was aspirated, which caused a disappearance of the abdominal mass." Decompression was then continued and on the fourth day the residual gastric contents amounted only to 600 cc.

On the eighth day his respirations became decreased in rate and his fingernails became cyanotic. Petechial hemorrhages appeared over his chest and arms. The heart showed a regular rhythm and a precordial Grade II murmur was present. The lungs remained clear to auscultation. His systolic blood pressure was 90. The respirations continued to decrease rapidly and the heart beat became inaudible. Intracardiac adrenalin® was given with no response and the patient expired.

CLINICAL DISCUSSION

DR. ZOLLINGER: Gentlemen, our patient was a 73 year old man who came to the hospital quite emaciated and dehydrated and complaining of pain. We find out from the past history that he had had a carcinoma of the rectum resected with an end-to-side anastomosis. So right away our thinking is directed towards some obstructive lesion resulting from this type of anastomosis, causing his feces to back up and rendering the ileocecal valve incompetent.

Perhaps it was this large bowel obstruction with an incompetent ileocecal valve that caused his pain, nausea and vomiting. But a barium enema some months before was negative and so was a sigmoidoscopy, although at the time of his admission he did not have a rectal examination, which probably should have been done.

On physical examination his blood pressure and his pulse were normal and the cardiorespiratory system seemed all right. But he had these peculiar masses in the left lower quadrant and we wonder whether this could have been dilated loops of small bowel or large bowel with fecal impaction, which might have been shown by rectal examination and which may have caused his diarrhea before he came in. A very important finding was his enlarged liver, which although smooth and firm was questionably tender.

The most obvious thing we are thinking about is large bowel obstruction, perhaps from his original lesion with an anastomosis, perhaps from a second carcinoma that had been missed, or perhaps due to adhesions. He had all these x-rays taken, but the masses in his mid-abdomen turned out to be a tremendously dilated stomach which was relieved by decompression. They ran serial x-rays of his small bowel and found that his small intestines were not obstructed, and by barium enema they demonstrated that his large bowel was not obstructed.

HYPOKALEMIA

They ran electrolyte determinations and found hypokalemia. With a history of four days of vomiting we would expect that this man must have hypochloremic alkalosis with hypokalemia. He also had an elevated blood urea nitrogen. His cephalin flocculation, his total proteins and albumin all point to a normal liver, although it was enlarged and although he had a bromsulphalein retention of 30 per cent. This is quite a lot above normal and therefore we must assume that there is a pathological process going on in the liver. So if we remember that this man had a carcinoma of the colon, which has a tendency to metastasize to the liver, we may conclude that this man's liver is being replaced by carcinomatous tissue, that perhaps the elevated blood urea nitrogen is due to large metastatic lesions. His white blood count remained high, suggesting that he had some localized inflammatory suppurative process, which agrees with the assumption of a localized area of tissue necrosis.

He was given potassium, sodium and chloride and he started to excrete 800 cc. of urine a day, which is not too much but is adequate. Could the right upper quadrant tenderness possibly come from his kidney and could the patient in addition suffer from renal disease? His urine examination proved that he could concentrate and was able to acidify and therefore he had a good kidney function.

I do not know how to explain his 2 to 1 heart block demonstrated by his electrocardiogram, because he always had a regular heart action. I suppose that a patient with hypokalemia could also have cardiac arrhythmias, but I do not know that they can contract auricular flutter from hyperkalemia. He was treated with daily aspirations of his stomach and lost this abdominal mass. He originally had 3500 cc. aspirated, which would mean a considerable loss of chloride and potassium, but from then on the amount of fluid obtained from his stomach amounted to roughly 600 cc. a day. That means to me that this patient did not have a pyloric or small bowel obstruction, and from the barium enema we deduce that he did not have a large bowel obstruction. Then why did this patient vomit for 4 days?

The only answer I have to that is that this was due to a paralytic ileus related to some localized inflammatory process that was causing this ileus and his stasis.

So from a practical standpoint, I may say that he has carcinoma with liver metastasis and that the necrosis of this metastatic lesion has produced prerenal azotemia. He did not have a small bowel obstruction. This brings up the problem of why this patient had these abdominal masses and pain. Perhaps he had a mesenteric thrombosis. I discard this. I admit that the blood count would agree with it and admit that a patient can live for eight days and sometimes longer after a mesenteric thrombosis. But he did not show blood in his stools at any time, nor did he have hematemesis, and his pain was not characteristic for it. Therefore, I do not think he had a mesenteric thrombosis.

DIFFERENTIAL DIAGNOSIS

That brings up the old problem of whether he could have a perforation of the stomach or duodenum. Could he have pancreatitis or a disease of the gallbladder? His pain was in the right upper quadrant and went around the chest to the back. Now if it were pancreatitis, it would be bandlike and would go through to the back. He did not have elevated serum amylase, so pancreatitis can be ruled out.

Then there is the possibility of a perforated peptic ulcer and a subphrenic abscess. X-ray could not demonstrate any air under the diaphragm, although I admit that one out of three cases will not show air under the diaphragm. His postprandial discomfort can be explained by a stomach full of fluid. He also had no past history related to stomach. There was no upper G. I. series reported, but I assume that the fluoroscopist did look at the stomach during his serial x-ray studies and could rule out any pathology. The same holds for duodenal ulcer.

The possibility of cholecystitis and cholelithiasis has to be considered. Perhaps the attack of right upper quadrant pain two months before his admission was an attack of cholelithiasis with cholecystitis. Perhaps he had a perforation of the gallbladder into the duodenum and he passed a gallstone and his obstruction then was due to a gallstone ileus. His x-rays do not substantiate the presence of a stone or of air in the hepatic radicles showing that he had a cholecystoduodenal fistula.

Then we come to the possibility of appendicitis. Could his cecum have had a long mesentery like any ascending colon may have and because of the transection of his transverse colon, could it have been pulled up in the right upper quadrant? Could his attack of pain originally therefore have been an attack of appendicitis with perforation and the formation of a localized abscess? Then he could have developed pylephlebitis with multiple liver abscesses. But that is just a presumption and I am inclined to throw that out.

Now, if we have ruled out intestinal obstruction and mesenteric thrombosis, what can we do to benefit this man from a surgical standpoint? He had a high white blood count, pointing to a localized abscess. We have to replace electrolytes, fluids, decompress him and of course put him on indicated antibiotics, which would have to be the broad-spectrum antibiotics. If he had a localized abscess in the right upper quadrant, then we would treat him expectantly and watch him because we would not go in and operate under his present condition. So if we came to that conclusion and we treated him that way, I would think we had done a good job.

But the patient died on the eighth day of this conservative management. Why did he die? His respirations became slower and stopped while his heart was still beating. That is suggestive to me that this man died a respiratory death perhaps from a massive pulmonary embolism. He had no sudden onset of pain and nothing to suggest coronary, but nevertheless his blood pressure gradually fell. So I would guess that this patient could have died on the eighth day from pulmonary embolism, because he had the perfect setup: age, carcinoma, dehydration, long bedrest and ileus. I would say as I analyze the case that this man had a necrotizing metastatic lesion with destruction of the liver and that he died from a pulmonary embolus.

CLINICAL DIAGNOSIS

1. Carcinoma of the colon.
2. Metastasis to the liver.
3. Paralytic ileus.
4. Pulmonary embolism.

PATHOLOGIC DIAGNOSIS

1. Carcinoma of the pancreas.
2. Metastasis to the liver and regional lymph nodes.
3. Multiple pulmonary vessel thrombosis with infarction.
4. Thrombosis of prostatic vessels.
5. Thrombophlebitis of the veins of the leg and arm.
6. Status post resection of the rectum for adenocarcinoma (nine and one-half months).
7. Status post transurethral resection of the prostate (nine and one-half months).

PATHOLOGIC DISCUSSION

DR. VON HAAM: The patient apparently was regarded to be a hopeless case when he returned to the hospital nine months after he had had an operation for carcinoma of the rectum. This carcinoma originally caused a little bloody streaking of his feces, and nine months ago they found on proctoscopic examination two little nodules

about 8 mm. in size which proved to be well-differentiated adenocarcinoma of the rectum. Eleven lymph nodes were examined but not a single lymph node showed metastasis. The patient at that time already had the pain in his right upper side, which of course was not relieved by cutting out a little polyp.

At that time no further exploration of the patient was done, and the operation was performed with a minimal amount of surgical exposure as they also wanted to resect his prostate.

The autopsy showed that sometimes you can be wrong in trying to bring all symptoms under one head. The patient was slightly dehydrated. He showed an enlarged left leg and right arm, which of course suggests the diagnosis of multiple thrombophlebitis. His liver showed a few nodular metastases. The lungs showed many infarcts and there were small vascular thrombi but no massive embolus. The pancreas was enlarged and was very firm, and the peripancreatic and retroperitoneal lymph nodes were all replaced by tumor tissue. There were also thrombi present in the vessels of the prostate, in the muscles of the left calf and in the portal vein.

MICROSCOPIC EXAMINATION

Sections through the heart showed only focal perivascular fibrosis. The vessels of the lungs were occluded by many small thrombi causing infarcts with early abscess formation. This must be considered the fatal lesion. Many thrombi were already organized, suggesting that this process must have been going on for some time.

The liver was the site of tumor metastasis but not of the type seen in primary carcinoma of the colon, which usually has the microscopic appearance of rather well differentiated adenocarcinoma with mucus-secreting tumor cells. The tumor present was instead a rather poorly differentiated adenocarcinoma with no trace of mucus secretion. In addition we saw in the liver evidence of circulatory disturbances with multiple foci of necrosis.

When we examined the pancreas we found that the patient had an extensive carcinoma of the head and body of the pancreas. Most of the organ was completely replaced by a poorly differentiated small-cell type of adenocarcinoma. The reason why the neoplasm did not cause biliary obstruction was the fact that the neoplasm started in the posterior and lateral portion of the head of the pancreas. There had been also a severe chronic pancreatitis before, and I feel that the patient must have suffered far more pain than he complained of. Many of his nerve trunks were invaded by tumor cells, which can account for his neurovascular and neuromuscular disorders, such as intestinal dilatation and paralytic ileus.

The carcinoma of the pancreas metastasized to the liver and to the retroperitoneal lymph nodes and not to those of the mesentery, where a carcinoma of the colon would be expected to metastasize. Examination of the remaining portion of the prostate also showed extensive thrombosis of the vessels, which of course could cause embolism in the lungs. There were also well-organized thrombi in the large veins of his left leg.

I think that this rather widespread thrombophlebitis presented a very definite clue which the clinicians did not consider. The carcinoma of the rectum was by all evidence only a very small tumor and I think we have all reason to regard the carcinoma of the rectum rather as the "red herring" in this patient's history. Of all conditions leading to thrombus formation, carcinoma of the pancreas is the outstanding disease, and whenever you make a diagnosis of thrombophlebitis in an older individual you should never forget to think at least and rule out carcinoma of the pancreas.

GENERAL DISCUSSION

MEDICAL STUDENT: How would you account for the petechiae in his arms and chest?

DR. VON HAAM: I think that the petechiae in this case could be explained in a similar way as the hemorrhages in thrombotic thrombocytopenic purpura, where the many spontaneous thrombi use up all available thrombocytes to the point of critical thrombocytopenia. Another explanation would be an increase of antithrombotic enzymes, like heparin.

MEDICAL STUDENT: What did the adrenals show?

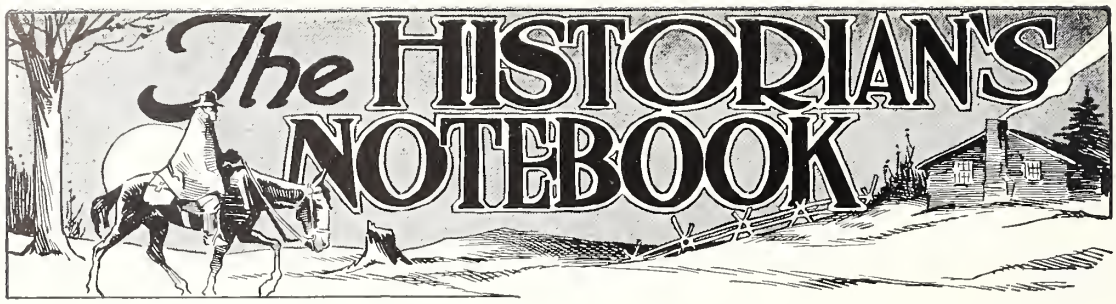
DR. VON HAAM: The adrenals showed nothing. The stomach was dilated and contained a little bit of bilious fluid. There was no bleeding, no hemorrhage, no ulcer.

DR. ZOLLINGER: How can you explain the elevated blood urea nitrogen?

DR. VON HAAM: Just as you explained it—on the basis of necrosis and hemorrhage. The kidneys were perfectly normal.

DR. TURLA: I did not quite understand the connection between carcinoma of the pancreas and his thrombophlebitis.

DR. VON HAAM: Well, Doctor, we cannot explain it either but it is a well-known observation. All malignant neoplasms increase the inclination to thrombus formation because every necrotized tissue produces blood clotting substances, but carcinoma of the pancreas, and particularly of the body of the pancreas, is especially outstanding in this respect. Therefore let me emphasize again, that whenever you see a case of unexplained thrombophlebitis in an old man, don't forget to consider carcinoma of the pancreas in the diagnosis, because the coincidence of the two conditions is so striking.



Meetings of the Faculty of Starling Medical College in 1859

JONATHAN FORMAN, M.D.

THE Museum of the Starling Medical College grew from a very modest beginning into a comparatively large one. With the merger of the College with The Ohio Medical University in 1907, some of the more unusual specimens were moved from the Park Street building where a few form a part of the present-day Pathologic Museum in Hamilton Hall. Among these were four instances of cancer of the lung—an exceedingly rare disease in those days. These, Dr. Ernest Scott and I described in a paper, in *The Medical Record*, on Lung Cancer. Among the others was a goodly number of monster-babies.—EDITOR.

MINUTES

Columbus, Ohio
January 4, 1859.

"The Faculty of the Starling Medical College met pursuant to an informal call at the office of Dr. Carter for the purpose of discussing certain of the rules and regulations written by Dr. Carter for the establishment and government of the College museum.

"These rules and regulations were read and discussed pro & con, and, after various amendments and corrections, were adopted and ordered to be recorded.

"Members present at the meeting were Doctors Dawson, White, Hamilton, Carter and Loving. Mrs. Carter was very kind and polite to the Faculty, furnishing the members with most excellent pastries &cc, not forgetting some good whiskey punch which made us all quite merry before the breaking up of the meeting.

REGULATIONS AND BYLAWS

FOR THE GOVERNMENT OF THE MUSEUM OF STARLING MEDICAL COLLEGE

"**Article I.** The Museum shall contain and consist of all such specimens and materials as are now or shall at any time become the property of the Trustees or Faculty of the College, whether they have, or may become so by donation of individuals or by purchase with funds of the college.

"**Article II.** It shall contain one or more cases, which may be contributed by every member of the Faculty, which, with the contents deposited by them, shall be and remain the sole property of the contributor and he liable to remove at his pleasure.

"**Article III.** It shall contain cases provided at the expense of the College, in which shall be deposited and safely kept the property of the College and such worthy material as shall be from time to time deposited with the Curator by individuals not members of the Faculty who may wish to retain ownership of the same and remove at pleasure.

"**Article IV.** In the event of the formation of an Association in this Faculty for the cultivation of natural science, such Association shall have full privilege of the Museum room to deposit, care for, and remove at its discretion such appropriate cases and material as they desire, always without detriment to the Museum or the College proper.

"**Article V.** The Faculty shall appoint a Curator who shall have charge of the property of the College in said Museum, as well as that of members of the Faculty. He shall see that it is properly arranged, labelled, and cared for; take charge of, give receipts for, and properly deposit contributions from all such as may desire to retain their rights of property in the articles contributed, return the same on proper demand, and generally do and perform all such duties as usually pertain to the office of Curator.

"**Article VI.** The museum shall be open under proper regulations to the use of students of the college, physicians, and members of the contemplated scientific association at all times, and

to the public in such manner as may be agreed upon by the Faculty and such Association when it is organized.

"**Article VII.** The Demonstrator of Anatomy shall be ex-officio Assistant Curator and is charged with the preservation and preparation of all valuable specimens of morbid anatomy which his office may bring to his hands. Such shall be the property of the college, while all other preparations or specimens which he may deposit may remain his private property, if he so wishes.

"**Adopted.**

"S. Loving, *Secy.*"

Saturday evening, Jan. 8, 1859

"Regular call. Minutes of preceding meeting read and adopted. Present: Doctors Dawson, White, Hamilton, Carter, Loving. Absent: Smith.

"The Dean said, according to instructions, he had made some enquiries concerning Mr. Russell, whose application for permission to be examined for the degree of Doctor in Medicine was before the Faculty at the last meeting; he had ascertained that Mr. Russell had only been engaged in the practice of medicine since 1854 and that it could hardly be supposed from what he had learned, that he had been engaged in regular practice even during that time. Upon learning this much, he had informed Mr. Russell that he could not be admitted to examination.

"Lovejoy, Miles & Benbow's estimates for repairs were presented by the Committee on Repairs and were as follows:

"Mr. Miles (T. J.) agreed to plaster the east tower, which contains the spiral staircase for $240.30.

"Thus: 46′ round by 92′3 = 424 (15x15x2x7) $31.50

7393 ÷ 9 = 821 sq. yd at 30 per sq. yd = $424.30.

"Mr. Lovejoy agreed to finish the stairway in the same tower for $102.00. He was to furnish all such material as may be necessary not furnished by the college.

"Morris and Benbow agreed to paint the roof of the central portion of the college and that of the dissecting room and repair the ribs of all the roofs of the dissecting room for $26.70 or about 5¢ per sq. yd for the paint and $2.00 for repairing the ribs.

"Mr. Miles' proposal *laid on the table* for future action.

"Lovejoy and Morris and Benbow's proposals *accepted*, and the Committee on Repairs instructed to have the work done as soon as possible.

"Dr. Wormley moved that the Committee on repairs be instructed to take charge of such lumber as may not be needed for the completion of the stairway and have it placed in a place of security, and further that the same committee be instructed to inquire by whom or on what authority such portions as have been used for purposes not collected with the college have been obtained. *Carried.*

"The Dean said he had made some enquiries concerning Mr. Keever, whose application for permission to be examined for the degree of Doctor of Medicine was before the Faculty at the last meeting. He said he had not elicited anything of a very favorable nature to the application and that he had not been able to see Mr. Keever. *Laid Over.*

"Then the Dean presented the application of Dr. Nelson of Tuscarawas County, petitioning for the honorary degree of Dr. of Medicine for Doctor E. C. Mann of Tuscarawas County, also letters from several gentlemen recommending Dr. L. Reynolds of Beverly, Washington County, as worthy of the honorary degree.

"The Faculty unanimously concluded that further recommendations were necessary in both cases, and, more particularly recommendations from physicians. The Dean was requested to obtain such as he could, and the applications were both *laid on the table* for further consideration.

"There being no further business, the Faculty adjourned, to meet Saturday evening, January 23, 1859.

"S. Loving, *Secy.*"

Disseminated Lupus Erythematosus

In 1885 Sir William Osler wrote as follows at the beginning of a thesis on ulcerative endocarditis: "It is of use from time to time to take stock, so to speak, of our knowledge of a particular disease, to see exactly where we stand in regard to it, to inquire to what conclusions the accumulated facts seem to point and to ascertain in what direction we may look for fruitful investigations in the future." So it is that I feel in regard to disseminated lupus erythematosus, a disease or condition about which much has been investigated and written during the past decade.

There is no known, specific etiology. Exposure to sunlight in susceptible individuals is apparently a factor in the precipitation of symptoms. It is generally believed that the female is predominantly affected, but the occurrence of lupus erythematosus in the male has been recognized. The age incidence is usually in the third and fourth decades, but diagnosis has been established in individuals as early as the second and as late as the sixth decades. It also is not uncommon in children. The race incidence is not known, but cases in the Negro race have been described. That an *x* factor exists is shown by the occurrence of spontaneous remissions of the disease process, some lasting for as long as fifteen to eighteen years.—Ferdinand Geiger, M. D., Syracuse, N. Y.: *New York State J. Med.*, 57:1915, June 1, 1957.

Principles of Hospital Accreditation . . .

Now Well Established, the Joint Commission Issues Statement To Clarify Some Misunderstandings as to Its Functions and Structure

EDITOR'S NOTE: At the 1957 Annual Meeting of the Ohio State Medical Association, the House of Delegates adopted a resolution requesting The Council of the OSMA to "obtain current information on what measures are being taken to correct certain unnecessary requirements that are enforced" within the framework of the Joint Commission on Accreditation of Hospitals and "to publish such information in *The Ohio State Medical Journal* with emphasis on those recommendations made by the Stover Committee which were not adopted."

This article is the first of a series which will be published by *The Journal* in compliance with the wishes of the House of Delegates and for the information of all members.

The second article will make a comparison between the recommendations which appeared in the AMA Stover Committee report and the present policies and precedures of the Joint Commission.

In subsequent articles *The Journal* will present suggestions and information from the Joint Commission on medical staff meetings, and medical records and will present answers by the Commission to many varied questions on the activities of the Commission, standards set by the Commission, hospital administrative problems, etc.

* * *

THE office of the Ohio State Medical Association receives many letters from time to time inquiring as to certain functions and actions of the Joint Commission on Accreditation of Hospitals. Apparently this trend extends widely, because Dr. Kenneth B. Babcock, secretary of the Joint Commission, has issued the following statment which reiterates some of the basic principles and program but at the same time answers prevailing questions. Here is the statement:

1. The Joint Commission is a voluntary nonprofit organization supported solely by contributions from its member organizations. Sponsoring organizations are the American Medical Association, the American Hospital Association, the American College of Physicians, the American College of Surgeons and the Canadian Medical Association. No charge is made for a survey of any hospital.

ELIGIBILITY RULES

2. Before applying for a survey for accreditation a hospital must be eligible. The eligibility rules are simple and as follows:

a. The hospital must have functioned for at least one year in its present capacity.

b. The hospital must have at least 25 adult beds.

c. The hospital must be listed by the American Hospital Association. For listing, application should be made directly to the American Hospital Association. Listing and accreditation are not synonomous, nor are they done simultaneously. Listing comes first, then accreditation. Any hospital, religious, private, nonprofit, governmental or proprietary institution which fulfills the eligibility requirements may apply for accreditation.

3. After a hospital applies for accreditation one month to one year may elapse before the hospital can be surveyed. Schedules for surveys are made up at least two months in advance and once made usually cannot be changed. Hospitals are notified usually two to three weeks in advance of the survey date. Because of travel conditions, hospitals in the south generally are surveyed in winter and those in the north in summer.

REPORTS STUDIED

4. After a survey the report is mailed to the office of the Joint Commission by the surveyor or his member organization. The surveyor's report contains his written recommendations for the improvement of patient care.

The staff of the Commission reviews the surveyor's report, any correspondence about the hospital, and the report of the previous survey to determine what action has been taken with respect to the recommendations made. The recommendations of the surveyor and the staff are sent to each Commissioner, who approves or disap-

proves them. The hospital is notified of the official action of the Commission.

VOTE BY COMMISSION

The whole process takes from 60 to 90 days. If the recommendations are disapproved by even one Commissioner the report to the hospital in question is held over until the Commissioners' meeting, when a vote is taken and a majority prevails.

a. Hospitals approved for three years are entitled to a Certificate. The hospital will automatically be resurveyed in approximately three years.

b. Hospitals approved for one year are not entitled to a Certificate and must return the previous Certificate if they have one. They will be automatically re-surveyed in approximately one year.

c. Hospitals which are not accredited must re-apply for survey if and when they feel that the standards can be met.

d. Dry runs or trial surveys by the Commission staff cannot be made. Neither the money nor personnel is available.

e. Only physicians are employed to survey hospitals. A great deal of an accreditation survey has to do with the quality of care and only a physician can attempt to assess this care.

BULLETINS AVAILABLE

5. The "Standards" of the Joint Commission are its basic document and every hospital medical staff, administrative staff and board of trustees should be acquainted with its contents. Bulletins of the Commission are published approximately every four months and contain for the most part interpretations and explanations of the Standards, plus other statistical information.

Multiple copies of all basic publications may be purchased for a nominal fee. A copy of every Bulletin is sent free to the administrator and the chief of staff of each hospital. It is their duty to see that essential information in the Bulletin is passed on to the medical staff and key personnel.

BASIC PHILOSOPHY

6. The primary and controlling purpose of the Joint Commission on Accreditation of Hospitals is to insure that the best possible quality care is provided in hospitals and to encourage improvement of patient care as rapidly as knowledge and experience permit.

This purpose is the natural result of the underlying philosophy of the accreditation program. The philosophy that hospitals must be evaluated from the point of view of the patient. In plain words "Is this hospital giving good quality care to the extent that I am willing for a member of yours or my family to be a patient in the hospital?"

Accreditation is not compulsory either on the part of the hospital or the accreditation body. It is not licensure. It is not government enactment. Accreditation is a voluntary effort on the part of every hospital, its medical staff, its board of trustees and its administration to raise the quality of patient care.

Sixth District Postgraduate Day Set for October 23 in Canton

Stark County will be host in Canton, Wednesday, October 23, for the annual Sixth Councilor District Postgraduate Day. Registration will be from 8:30 to 9:30 A. M. at the Onesto Hotel and all meetings, with the exception of the Obstetrics and Gynecology Sections, will be at the Onesto. Following registration at the Onesto, the Obstetric and Gynecology meetings will be at the Y. M. C. A. one-half block away, until 3:45 P. M. At 4 P. M. they will join the medical and pediatric sections in the combined panel on "Adolescence" to be held at the Onesto.

An excellent group of speakers from many sections of the United States has been obtained and their topics will be of interest to all physicians. The speakers to date include:

Dr. William Bennett Bean, professor of medicine, University of Iowa.

Dr. Donald B. Effler, chairman Department Thoracic Surgery, Cleveland Clinic.

Dr. J. R. Gallagher, physician-in-chief, Adolescent Clinic, Peter Bent Brigham Hospital, Boston.

Dr. William P. Given, assistant professor of obstetrics and gynecology, Cornell.

Dr. John W. Gofman, Institute of Medical Physics, Belmont, California.

Dr. Paul György, professor of pediatrics, University of Pennsylvania.

Dr. Leon Israel, chief of gynecology, Graduate Hospital, University of Pennsylvania.

Dr. Carl T. Javert, director of obstetrics and gynecology, Woman's Hospital, Division of St. Lukes, New York City.

Dr. Clark Randt, director of neurology, Western Reserve.

Dr. Louis Rousselot, professor of surgery, Columbia.

Dr. Cornelius Sedwick, Lahey Clinic.

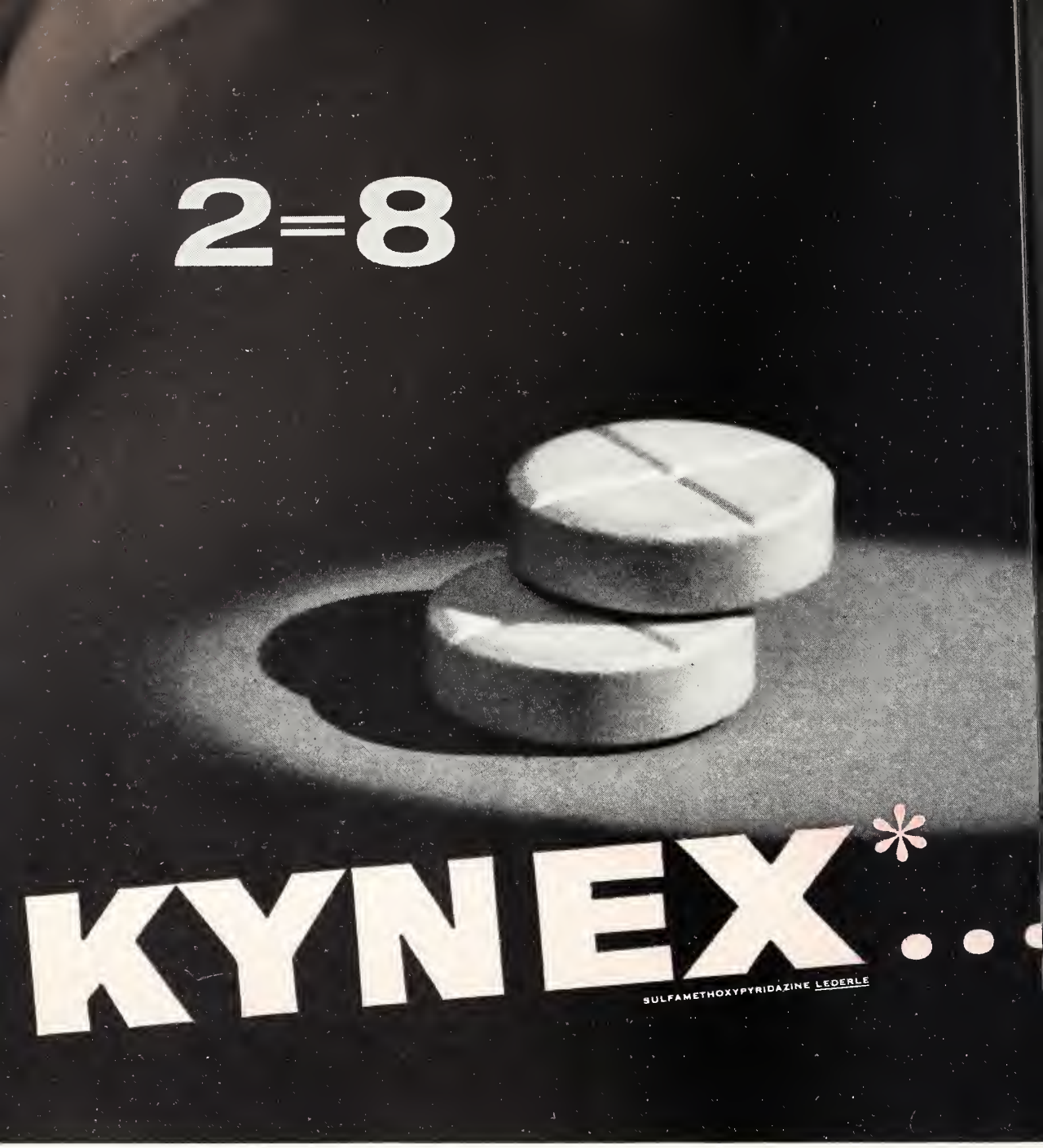
Dr. Orvar Swenson, associate professor of surgery, Harvard.

Dr. Philip Tumulty, associate professor of medicine, Johns Hopkins.

Dr. Robert Zollinger, professor of surgery, Ohio State.

Their topics will be listed in detail at a later date.

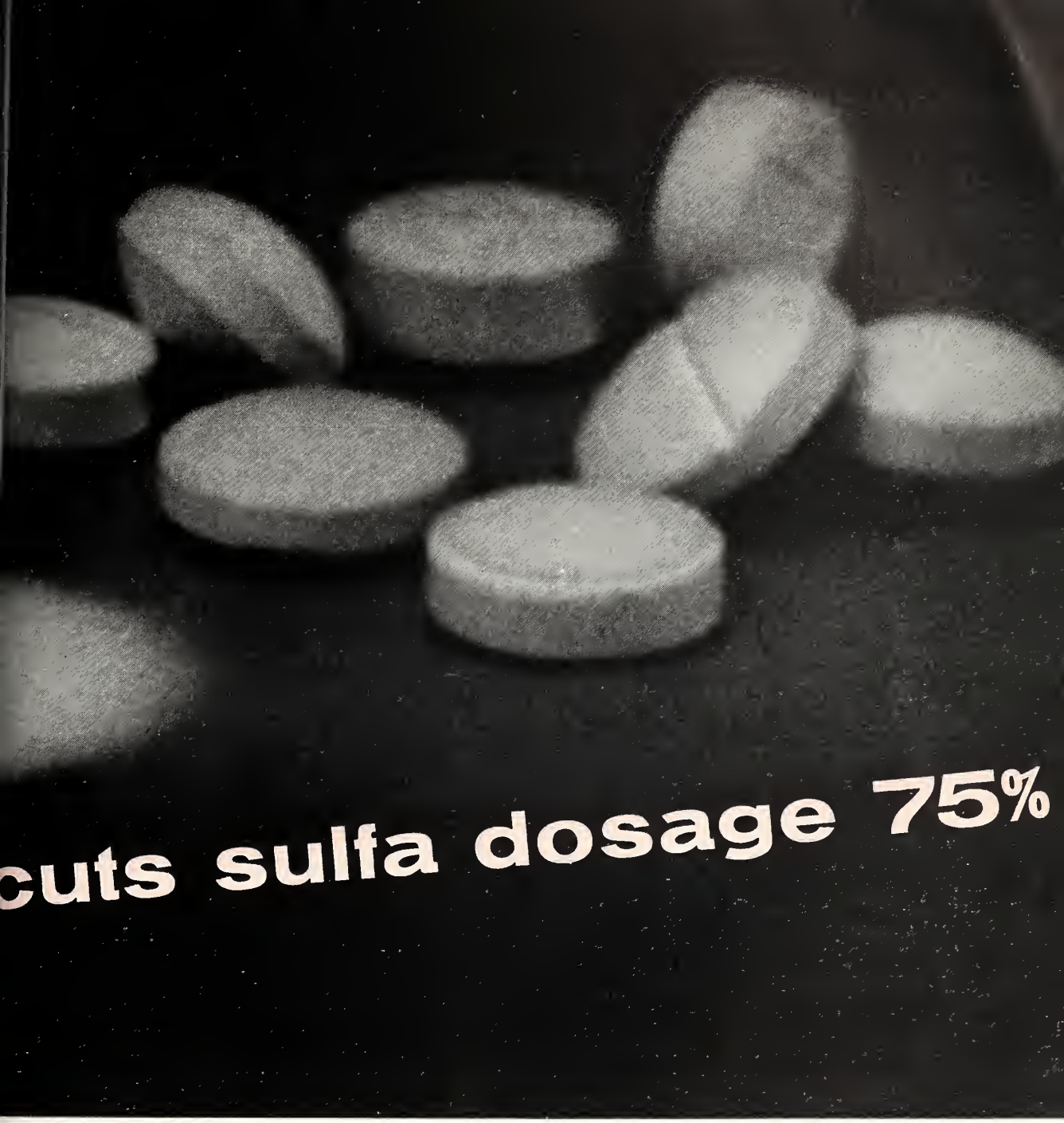
The medical auxiliary has also planned an interesting day including luncheon and a style show. They will join their husbands at the prebanquet reception and banquet following the afternoon meetings.



24 hour therapeutic

blood levels with

a single (1 Gm.) dose



YNEX Sulfamethoxypyridazine, the new, long-acting sulfonamide, now enables the physician to attain more effective ulfa therapy with these unequaled clinical advantages—

OW DOSAGE[1] —only 2 tablets per day.

APID ABSORPTION[1] —therapeutic blood levels within the our, blood concentration peaks within 2 hours.

ROLONGED ACTION[1] —10 mg. per cent blood levels that ersist beyond 24 hours on a maintenance dose of 1 Gm.

ROAD-RANGE EFFECTIVENESS—particularly efficient in urinary tract infections due to sulfonamide-sensitive organisms, ncluding E. coli, Aerobacter aerogenes, paracolon bacilli, treptococci, staphylococci, Gram-negative rods, diphtheroids nd Gram-positive cocci.

Reg. U.S. Pat. Off.

GREATER SAFETY —high solubility, slow excretion and low dosage help avoid crystalluria. No increase in dosage is recommended; the usual precautions regarding sulfonamides should be observed.

CONVENIENCE —the low maintenance dosage of 1 Gm. (2 tablets) per day for the average adult offers optimal convenience and acceptance to patients.

TABLETS: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100.

SYRUP: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

(1) Boger, W. P.; Strickland, C. S. and Gylfe, J. M.: Antibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

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Legislation . . .

Outstanding Record Set by General Assembly on Medical and Health Matters; How Representatives and Senators Lined Up on H.B. 384

THE regular session of the 102nd Ohio General Assembly which ended in mid-June established an outstanding record in the field of medical and health legislation.

It constituted an exceedingly busy session for the Legislative Committee of the Ohio State Medical Association, officers and legislative chairmen of County Medical Societies, and representatives of the Columbus Office staff.

The 1957 legislative session was an especially difficult one for OSMA representatives because of the highly controversial bill (House Bill 384) to provide a more adequate supply of unclaimed dogs for medical teaching and research, which was passed by a substantial vote and will become effective September 13.

This article, in addition to presenting a detailed account of the enactment of H. B. 384, is a general roundup on all the medical-health measures which were considered by the 102nd General Assembly, as well as some reference to other bills of general interest to physicians.

BILLS TOTAL 1384

Bills introduced in both houses totaled 1384, of which 940 were House bills and 444 Senate bills. About 150 bills, relating in some way to medicine, public health, welfare, hospitals, etc., were followed closely by representatives of the Association. Hearings were attended and testimony was offered on many measures.

A recapitulation of the work of the 102nd Ohio General Assembly shows that 134 Senate bills and 202 House bills were passed for a total of 336. Of these, Governor O'Neill vetoed four, leaving a total of 332 enactments.

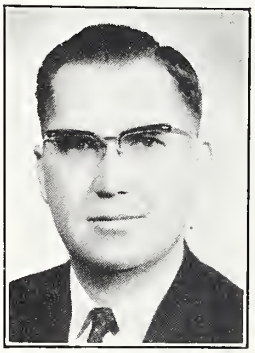
Regular bulletins were issued weekly by the OSMA office to county medical society officers and legislative chairmen. Special bulletins on certain bills were sent out when the situation demanded.

No legislation deemed detrimental to medical and health standards was enacted. Several bills of importance to medicine and health became laws. This is tangible evidence that officials and legislative chairmen of county medical societies in general did a fine job in interviewing legislators and letting them know of the attitude of the medical profession on medical and health proposals.

Much credit for the constructive record of the 102nd General Assembly should go to House Speaker Roger Cloud of DeGraff, and to Senator C. Stanley Mechem, Nelsonville, president pro tem of the Senate. Speaker Cloud was ably assisted by House Floor Leader Kline L. Roberts of Columbus.

HEALTH COMMITTEES COMMENDED

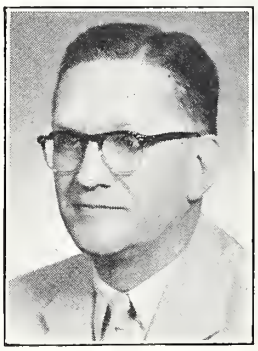
Regarding health measures in general, the work of Health Committee Chairman Harold W. Oyster, Washington County's veteran representative, was outstanding. Most of the members of his committee, many of them "first-termers," deserve commendation for their conscientious investigation and study of legislation which was before them.



REPRESENTATIVE OYSTER

Bulwarks on the House Health Committee were Mrs. Clara E. Weisenborn, Montgomery County, vice-chairman of the Committee; Vernon G. Hisrich, Tuscarawas, County, who served as secretary, a position which he also held in the 101st General Assembly, and veteran Health Committee member John Hayden, Clermont County.

These first-term members of the Assembly who served on the Health Committee distinguished themselves also, because of their outstanding record on medical-health proposals: Representatives John Ashbrook of Licking County; Charles F. Kurfess of Wood; John C. Pollock of Lake; and Archer E. Reilly, Jr., of Franklin.



SENATOR MOSHER

Senator Charles A. Mosher, Lorain County, Chairman of the Senate Committee on Education and Health, was exceedingly helpful to OSMA representatives and as usual had a fine record on medical-health legislation.

Cooperation on medical-health legislation was accorded the Association by the following members of the Senate Committee on Education and Health: Senators Oakley C. Collins, Lawrence County; Gordon Renner, Hamilton County; Ross Pepple, Allen County; William Beckett, Butler County; C. Lee Mantle,

Snapped As Governor O'Neill Signed House Bill 384



Lake County; Charles J. Carney, Mahoning County; and Julius J. Petrash, Cuyahoga County. Also helpful was Senator Joseph W. Bartunek, Cleveland, Minority Floor Leader of the Senate.

General appropriations to operate the State of Ohio for the biennium beginning July 1, 1957 and ending June 30, 1959 totaled $1,167,315,755. Appropriations and reappropriations for capital improvements amounted to $143,871,107 for the same period.

The General Assembly failed to appropriate sufficient money to finance the Health Care Program of the Division of Aid for Aged for the next two years on the same level as the fiscal year, 1956-57. The Division asked for approximately $29-million for the biennium, 1957-58 and 1958-59. The Legislature appropriated only $18-million, leaving a shortage of $11-million which compelled the Division to reduce fees and allowances to physicians, hospitals, and others rendering services to recipients of the Division.

RESEARCH BILL PASSED

House Bill 384, making unclaimed dogs available for medical research and teaching, was signed into law by Governor C. William O'Neill on June 14, having been approved in the House by a vote of 75 to 57 on May 1, and in the Senate, 22 to 9, on May 22.

Many hours of strenuous and effective work on the part of physicians, county medical societies, sympathetic legislators, and the OSMA legislative staff will be rewarded when this enactment becomes effective as a state law on September 13.

In itself a comparatively simple piece of legislation, the act requires that unwanted, abandoned, unclaimed dogs which are incarcerated in pounds must be offered to research institutions which have been certified by the Ohio Public Health Council 24 hours before they are put to death.

Opposition to the bill took the form of extensive letter writing and newspaper advertising campaigns on the part of humane societies and anti-vivisectionists. Legislators and editors were swamped with letters opposing the bill.

OSMA strategists refused to be drawn into a position of debating this issue on an emotional basis. It was felt that the bill would stand on

its own merits, if presented factually to the members of the Ohio General Assembly.

A brief booklet was published, outlining the need for the bill and its provisions and containing endorsements of the deans of Ohio's three medical schools. The need for the dogs and their importance in bringing to the public the benefits of medical research were emphasized.

Not only was the booklet presented to members of the House and Senate, but it was also sent to every member of the Ohio State Medical Association. This enabled individual physicians as well as legislative committeemen to discuss the bill factually with their assemblymen.

The majority of legislators responded favorably. See the table on page 937 to ascertain how yours voted.)

BILL WELL SUPPORTED

This type campaign attracted the attention of legislative correspondents and newspaper editors, and the bill received editorial support from most of Ohio's larger dailies.

A Special Subcommittee on Research Legislation was set up by the OSMA Council to gather facts, outline strategy, and testify before legislative committees with regard to the bill. Members were: Doctors Thomas D. Kinney, professor of pathology, Western Reserve University School of Medicine, chairman; Arthur C. Corcoran, assistant director of research division of Cleveland Clinic Foundation; Eric Ogden, professor of physiology and medicine, and Robert N. Watman, assistant professor of surgery, Ohio State University College of Medicine; George H. Acheson, professor of pharmacology and James A. Helmsworth, assistant professor of surgery, University of Cincinnati College of Medicine.

Doctors Kinney, Ogden and Acheson, and Dr. Fiorindo A. Simeone, Professor of Surgery at Western Reserve University College of Medicine, appeared before the House and Senate Committees as expert witnesses. Their excellent presentations won the acclaim of members of the Assembly and the press.

The Hon. J. Frank McClure of Ashland, Chairman of the House Finance Committee and one of the veteran leaders of the General Assembly, appeared in behalf of the bill when it was heard in the House and Senate Committees and spoke for it on the floor of the House. Mr. McClure stated that his life was saved some years ago due to findings developed by research on dogs.

Dr. Robert Browning, Director of the Ohio Tuberculosis Hospital, Columbus, representing the Ohio Director of Health, spoke for the bill before the House Health Committee, as did Mr. James Merritt, representing the Ohio State Pharmaceutical Association.

MEASURE ABLY GUIDED

Representative Oyster was the author of the bill and received widespread commendation for his expert handling of the measure through the House and as a witness before the Senate Committee on Education and Health.

When the bill reached the Senate it was ably guided by Senator Mosher.

Similar legislation has been enacted in eight other states: Delaware, Illinois, Minnesota, New York, Oklahoma, South Dakota, Wisconsin, and Massachusetts. The Massachusetts enactment occurred in the current legislature, climaxing more than a score of years of effort on the part of the State Medical Society.

Other medical-health bills kept OSMA representatives on the jump and necessitated attendance at many hearings.

Defeat of House Bill 5, which would have set up a separate licensing board for chiropractors, was a victory to preserve high medical and health standards in Ohio.

George H. Saville, Director of Public Relations for the Ohio State Medical Association, appeared before the House Health Committee and effectively presented the Association's case against the measure.

CHIROPRACTIC BILL KILLED

This bill was killed in Committee by a vote of 10 to 1 after a motion to report it out for consideration received only 3 affirmative votes.

Those who voted with the OSMA against the Chiropractic Bill were Representatives Oyster, Ashbrook, Hayden, Kurfess, David M. Phillips of Ross County, Pollock, Reilly, Weisenborn, Anne M. Donnelly, Cuyahoga County and Hisrich.

Those who supported the chiropractors and the bill were: Representatives Harry Corkwell, Putnam County, George Hook, Brown County, and Norman A. Fuerst, Cuyahoga County.

Effective work of physicians back home again was instrumental in dealing with this dangerous legislation.

Another chiropractic bill was introduced in the Senate, S. B. 369 but did not "see the light of day" since it was never printed or scheduled for hearing.

House Bill 809 which would have compelled Ohio to recognize "Naturopathy" and provided for licensing by the Ohio State Medical Board was not printed. It died in the Health Committee of the House.

House Bill 866 which would have given mechanotherapists the right to use anesthetics and secure narcotics permits also expired in the House Health Committee. It was not printed.

All three of the above bills were opposed by the Ohio State Medical Association.

BILLS ENACTED

The following bills of interest to the medical profession were enacted into law, in addition to measures discussed above:

S. B. 108, increases from fifty cents to one dollar the fee paid to the Director of Health for a

certified copy of any record registered with the Department of Health; the fee paid to a local health commissioner for a certification of birth; the fee paid to a local registrar for an exact copy of any record of birth, death, or stillbirth, and the fee paid for each hour of search of the records in the Department of Health when no certified copy of certification of record is issued. **Effective August 20, 1957.**

S. B. 140, establishes an alcoholism research program in the College of Medicine at the Ohio State University; authorizes research and, within available funds, the examination, evaluation, treatment, rehabilitation and care of alcoholics. **Effective, September 13, 1957.**

S. B. 246, makes possible group life insurance covering associations of medical, dental, accounting, and legal professions, providing that such associations have been in existence for two years preceding purchase of such insurance and provided there are at least 50 members and at least 50 per cent of the membership insured. **Effective, September 13, 1957.**

S. B. 250, grants the State Board of Pharmacy additional authority to revoke or suspend licenses for fee splitting; allowing someone other than a pharmacist to practice pharmacy, and having connection with illegal practitioner; and increases fine for illegal dispensing of drugs and improper operation of drugstore. **Effective, September 16, 1957.**

S. B. 318, requires the Director of Health to study problems concerning air pollution and to maintain a laboratory for air pollution research and empowers the director to cooperate with other agencies, to disseminate information and to accept funds for purposes relative to air pollution. **Effective, September 7, 1957.**

S. B. 339, to establish an atomic energy coordinator and advisory council and certain state controls. At the suggestion of the OSMA it carries a provision that the act shall not prohibit or limit, or require an additional license for the use of radio-active by-products for medical purposes by physicians already holding a license to practice medicine in Ohio. **Effective, September 9, 1957.**

S. B. 360, increases from one-third to two-thirds of a grain the amount of dihydrocodeinone which may be dispensed or administered in a 48-hour period without the keeping of a record. **Effective, September 13, 1957.**

H. B. 64, permits boards of county hospital trustees, boards of governors of joint township district hospitals and directors of public safety of municipal corporations charged with management and control of hospitals to employ legal counsel to bring action to collect delinquent accounts. **Effective, September 16, 1957.**

H. B. 104, to amend the laws governing Brucellosis, prescribing detailed changes relative to testing and control of diseased animals. **Effective, July 24, 1957.**

H. B. 294, authorizes the State Director of Health to regulate the use of fluoroscopes for non-medical purposes. This measure concerns the use of shoe-fitting devices which emit potentially hazardous radiation. **Effective, September 9, 1957.**

H. B. 322, places institutions of political subdivisions which provide medical and nursing care under the minimum standards established by the Ohio Department of Health for hospitals, thus making such institutions conform with requirements of the 1950 social security act amendments and eligible for federal aid. **Effective, September 16, 1957.**

H. B. 327, providing that the proceeds from the sale of old St. Francis Hospital in Columbus accrue to the Ohio State University College of Medicine. **Effective, May 28, 1957.**

H. B. 560, makes mandatory a county welfare department in every county. **Effective, January 1, 1959.**

H. B. 568, to permit boards of education to establish separate schools or facilities for mentally retarded children and to expend school funds for this purpose. **Effective, September 16, 1957.**

H. B. 569, enumerates conditions under which the registrar of motor vehicles may issue "restricted" operator's licenses to persons with physical impairment. Includes authorization to the registrar for issuing such a license, good for six months, to an individual who is or has been subject to epilepsy if he presents a statement from a licensed physician that such condition is under effective medical control. A medical board of review is created to hear appeals from adverse decisions of the registrar. **Effective, September 16, 1957.**

H. B. 649, adds to the list of physical and mental diseases or conditions existing prior to employment for which workmen's compensation losses are not charged to the employer's experience: hemophilia, chronic osteomyelitis, ankylosis of joints, hyperinsulinism, muscular dystrophies, arteriosclerosis, thrombophlebitis and varicose veins. This measure seeks to encourage the employment of physically handicapped persons. **Effective, September 4, 1957.**

H. B. 667, is the uniform food, drug, device and cosmetics act. **Effective, September 13, 1957.**

H. B. 836, provides medical, dental, optometrical and hospital care for needy permanently and totally disabled persons, in order to encourage rehabilitation. **Effective, September 16, 1957.**

H. B. 889, authorizes the administrator of the Bureau of Workmen's Compensation to submit

medical questions in claims to a medical advisory board. **Effective September 6, 1957.**

MEASURES NOT ENACTED

In addition to bills already mentioned, a number of other medical-health bills were killed in committee or were never brought to hearing. The additional bills of interest which were not enacted covered these subjects:

Extend state aid to the needy chronically ill to the present public assistance programs for the aged, blind, dependent children, etc.

Permit Ohio to enter into health compacts with other states for the care of the mentally ill.

Create a state board to license and regulate medical technicians.

Make disability from exposure to radio-active materials compensable under the Workmen's Compensation Act.

Establish a state board to examine and license dispensing opticians.

Specify that one member of the Ohio Public Health Council be a dentist.

Authorize the superintendent of each state mental hygiene institution to appoint an advisory committee.

Establish a temporary disability compensation program in Ohio as part of Unemployment Compensation System under which lost-time compensation and medical-hospital costs would be paid to those unable to work because of off-the-job illness or injury.

Exempt prescription medicine, artificial limbs, etc., from the sales tax.

Create a separate board to examine and license masseurs, now licensed under the Limited Practice Section of the State Medical Practice Act.

Make it illegal for a hospital to prohibit any physician from using the facilities of the institution.

Appropriate $3 million to reimburse hospitals for training student nurses.

Make the State Board of Education the agency to hear appeals from state licensing boards rather than the present commission composed of state auditor, treasurer, and secretary of state.

Increase penalties for practicing medicine without a license and add injunction to present penalty.

Raise the per day allowance of Board of Health Members from $3 to $6.

Permit private insurance carriers to write Workmen's Compensation Insurance in competition with the State Fund.

Permit issuance of marriage license to epileptics under certain conditions.

Provide that non-profit voluntary health and welfare organizations need pay only one dollar for license under law licensing food service operations.

Permit establishing of non-profit dental care organizations.

Delete the requirement that there must be a physician on the State Cosmetology Board.

Require signature of one physician instead of two on mental hygiene commitment certification.

Eliminate $65 a month ceiling on old age pension and drop citizenship requirements.

Create a three-member state board of hospitalization, appointed by the Governor to represent the public interest in hospitalization service associations.

Require detailed report of organization of hospitals and charges for services, salaries, etc., in order to be eligible for per diem disbursements to hospitals for indigent motor vehicle injury cases.

Require city and general health districts to provide for polio immunizations without costs, for all persons under 19 years of age.

Provide for licensing of rest homes by the State Department of Health.

Make the county the local relief area, eliminating city relief areas.

Provide more practical methods for consolidating health departments within a county, and to facilitate the merger of city and general health districts.

Chief Provisions of House Bill 384—Medical Research Measure

The principal provisions of H. B. 384 are found in Sec. 955.16 of the Revised Code, as amended by the bill, and reading as follows:

Sec. 955.16. Dogs not wearing valid registration tags, which have been seized by the county dog warden and impounded, shall be kept, housed, and fed for three days for the purpose of redemption as provided by section 955.18 of the Revised Code unless immediate humane destruction of a dog is necessary because of disease or injury. At * any time after said three day period of redemption, any such dog not so redeemed may be sold; provided, no *** dog sold to a person other than an institution or organization of the type described herein shall be discharged from said pound until such animal shall have been registered and furnished with a valid registration tag.**

Any dog not redeemed within three days from the time it is seized and impounded may, upon payment to the dog warden or poundkeeper of the sum of three dollars, be sold to any Ohio institution or organization not for profit which is certified by the Ohio public health council as being engaged in teaching or research concerning the prevention and treat-

ment of diseases of human beings or animals. Any dog so sold to any such institution or organization shall be discharged from said pound without registration, and may be kept by such institution or organization without registration so long as said dog is used for such teaching and research purposes.

Any institution or organization certified by the Ohio public health council which obtains dogs for teaching and research purposes pursuant to the provisions of this section, shall at all reasonable times, make such dogs available for inspection by agents of the Ohio humane society, appointed pursuant to section 1717.04 of the Revised Code and agents of county humane societies appointed pursuant to section 1717.06 of the Revised Code, in order that such agents may prevent the perpetration of any act of cruelty, as defined in section 1717.01, to such dogs.

Any dog which the dog warden or poundkeeper shall be unable to dispose of, in the manner provided by sections 955.16 and 955.18 of the Revised Code, may be humanely destroyed except that no dog shall be destroyed until twenty-four hours after it has been offered to an institution or organization not for profit as provided in this section which has made a request for dogs to the dog warden or poundkeeper.

Any owner of a dog that is wearing a valid registration tag, who presents such dog to the dog warden or poundkeeper, may specify in writing that such dog shall not be offered to an institution or organization not for profit as provided in this section.

A record of all dogs impounded, the disposition of the same, the owner's name and address where known, and a statement of costs assessed against such dogs shall be kept by the poundkeeper and he shall furnish a transcript thereof to the county treasurer quarterly.

A record of all dogs received and the source of supply of such dogs shall be kept, for a period of three years from the date of acquiring such dogs, by all institutions or organizations engaged in teaching or research concerning the prevention and treatment of diseases of human beings or animals.

Representatives Who Voted For H. B. 384

(Adams) Games
(Ashland) McClure
(Auglaize) Katterheinrich
(Belmont) Lancione
(Brown) Hook
(Butler) Jones
(Butler) Sexton
(Carroll) Longsworth
(Champaign) Long
(Clark) Bayley
(Clark) Kitchen
(Clermont) Hayden
(Clinton) Dennis
(Columbiana) Wetzel
(Cuyahoga) Gorman
(Cuyahoga) Kilbane
(Cuyahoga) O'Donnell
(Cuyahoga) Sawicki
(Darke) Longfellow
(Defiance) Baker
(Delaware) Jenkins
(Erie) Swanbeck
(Fairfield) Lantz
(Franklin) Chester
(Franklin) Metcalf
(Franklin) Reilly
(Franklin) Zuber
(Fulton) Rychener
(Gallia) Taber
(Geauga) Broughton
(Greene) Ankeney
(Hamilton) Bullock
(Hamilton) Glandorf
(Hamilton) Reckman
(Hamilton) Schneider
(Hancock) Cole
(Harrison) Milleson
(Henry) Thurston
(Highland) Milner
(Holmes) Gindlesberger
(Huron) Jump
(Jefferson) Loha
(Lake) Pollock
(Lawrence) Crowe
(Licking) Ashbrook
(Madison) Kile
(Mahoning) Lynch
(Marion) Robinson
(Medina) Johnson
(Meigs) Meinhart
(Mercer) Raudenbush
(Miami) Short
(Monroe) Heft
(Montgomery) Weisenborn
(Morgan) Beckwith
(Noble) James
(Ottawa) Rofkar
(Paulding) Miller
(Pickaway) Wallace
(Pike) Leist
(Portage) Watters
(Preble) Pierson
(Putnam) Corkwell
(Sandusky) Lahr
(Scioto) Woods
(Seneca) Turner
(Shelby) Milligan
(Summit) McGovern
(Tuscarawas) Hisrich
(Van Wert) Bellis
(Washington) Oyster
(Wayne) Fisher
(Williams) Gardner
(Wood) Kurfess
(Wyandot) Cassell

Representatives Who Voted Against H. B. 384

(Allen) White
(Ashtabula) Shaylor
(Athens) Ward
(Coshocton) Berry
(Crawford) Drake
(Cuyahoga) Bartunek
(Cuyahoga) Corrigan
(Cuyahoga) Day
(Cuyahoga) Donnelly
(Cuyahoga) Fuerst
(Cuyahoga) Horvath
(Cuyanoga) McCaffery
(Cuyahoga) McGettrick
(Cuyahoga) Miller
(Cuyahoga) Novak
(Cuyahoga) Pokorny
(Cuyahoga) Sullivan
(Fayette) Perrill
(Franklin) Edmonston
(Guernsey) Sheppard
(Hamilton) Groneman
(Hamilton) McClure
(Hamilton) Rogoff
(Hamilton) Simmonds
(Hamilton) Taft
(Hardin) Lady
(Hocking) Bright
(Jackson) Owens
(Knox) Porterfield
(Lorain) Burge
(Lorain) DeChant
(Lucas) Connors
(Lucas) Devine
(Lucas) Galvin
(Lucas) Reno
(Lucas) Reynolds
(Mahoning) Gilmartin
(Mahoning) Tablack
(Montgomery) Mills
(Montgomery) Roderer
(Montgomery) Whalen
(Montgomery) Yoder
(Morrow) Hildebrand
(Perry) Mills
(Richland) Robinson
(Ross) Phillips
(Stark) Bauer
(Stark) Hawk
(Stark) Hiner
(Stark) Lehmann
(Summit) Rowe
(Summit) Smith
(Summit) Sours
(Summit) Thomas
(Trumbull) Kilpatrick
(Union) Caryl
(Vinton) Boring

Those Absent or Not Voting—Speaker Cloud (Logan), Roberts (Franklin), who was presiding when vote was taken, Crosser (Cuyahoga), Sweeney (Cuyahoga), Zellar (Muskingum), Williams (Trumbull), Stanley (Warren).

Senators Who Voted For H. B. 384

Joseph W. Bartunek, Cuyahoga County
William Beckett, Butler County
Anthony O. Calabrese, Cuyahoga County
Charles J. Carney, Mahoning County
Oakley C. Collins, Lawrence County
Fred W. Danner, Summit County
David McK. Ferguson, Guernsey County
Lowell Fess, Greene County
Theodore M. Gray, Miami County
Fred Harter, Summit County
Clarence Krueger, Erie County
C. Lee Mantle, Lake County
C. Stanley Mechem, Athens County
Tom V. Moorehead, Muskingum County
David E. Morgan, Franklin County
Charles A. Mosher, Lorain County
Stephen R. Olenick, Mahoning County
Ross Peppel, Allen County
Gordon Renner, Hamilton County
Robert R. Shaw, Franklin County
J. E. Simpson, Hardin County
Ed Witmer, Stark County

Senators Who Voted Against H. B. 384

Arthur Blake, Belmont County
Frank D. Celebrezze, Jr., Cuyahoga County
Julius J. Petrash, Cuyahoga County
Andrew C. Putka, Cuyahoga County
Raymond E. Hildebrand, Lucas County
Frank W. King, Lucas County
Fred L. Hoffman, Hamilton County
William Tyrrell, Preble County
Frank J. Svoboda, Cuyahoga County

Those Absent or Not Voting were: William H. Deddens, Hamilton County; Delbert L. Latta, Hancock County; and I. E. Baker, Montgomery County.

Emergencies Under Medicare . . .

Emergency Must Come Under Specified Categories To Be Included Under Medicare: Dental Care Included Only as Adjunctive Service

THE following additional information on the Dependents' Medical Care Program (Medicare) is from Major General Paul A. Robinson, executive director of the program, Washington, D. C. The Fiscal Administrator for the Medicare program in Ohio is Mutual of Omaha, Post Office Box 1298, Omaha, Nebraska.

1. **Emergency Care** (Reference Joint Directive)

Misinterpretations concerning the types of emergency care authorized under the Dependents' Medical Care program appear to exist in various areas throughout the country. It is the intent of the following discussion to clarify the emergency care aspects of the program in order that any erroneous misinterpretations can be corrected.

Acute emergency care of any nature in a **hospital** is covered under the program. Such emergency care for an illness or condition not otherwise covered is only authorized pending arrangements for care elsewhere. (Paragraph 502 g of Joint Directive.)

When admitted to a hospital for emergency care the medical facility to which admitted need not meet the definition of a "hospital" as stipulated by the Joint Directive (paragraph 601 a.). However, this does not eliminate the requirement for **admission as an inpatient to a medical facility** for 18 consecutive hours or more except for shorter periods of hospitalization for surgical procedures, treatment of fractures or other bodily injuries, or in instances in which death occurs in a lesser period of time. (Paragraph 503 b of Joint Directive.)

Consequently, emergency treatment is not in itself sufficient grounds for inclusion within the Dependents' Medical Care Program.

Essentially, the Dependents' Medical Care Program is an inpatient program providing for outpatient care only in the following areas:

1. **Obstetrical and Maternity Services** (paragraphs 502 d and 503 d(2)).

2. **Bodily Injuries**, limited to the treatment of fractures, dislocations, lacerations and other wounds (paragraphs 502 f and 503 d(3)).

3. **Diagnostic Tests and Procedures** prior to and/or following hospitalization for the same **bodily injury** or **surgical procedure** for which hospitalized (paragraph 503 d(1) (d)).

4. **Radio Therapy** prescribed during a period of hospitalization and continued or carried out on an outpatient status (paragraph 2 of ODMC Letter No. 3).

Irrespective of the existence of an emergency the above constitutes the only areas in which outpatient care can be authorized under the program.

In view of the foregoing, emergency care to be payable by the Government under the Dependents' Medical Care Program must be either:

1. Outpatient care as stated above which is normally provided for under the program; or

2. Care furnished to a patient who is **admitted to a hospital as an inpatient** irrespective of whether the hospital meets the definition of a "hospital" as defined in the Joint Directive.

This eliminates from coverage emergency care, not related to an obstetrical or injury case, that is performed in a doctor's office or clinic.

2. **Government Liability in Obstetrical and Maternity Services**

Two questions have been raised concerning the scope of obstetrical and maternity services for which the Government is liable. Although varying terms are used in the Joint Directive, such as "obstetrical and infant care," "complete obstetrical and maternity care," and "complete obstetrical and maternity services," the governing limitation of the Joint Directive is the definition of **Maternity and Infant Care** (paragraph 103j (3)). That definition includes the provision "incident to pregnancy." Hence, outpatient "antepartum" care of pseudocyesis, or the outpatient administration of examinations and diagnostic procedures which lead to diagnosis that the patient is not pregnant, are not proper charges against the Government under Public Law 569—84th Congress.

ADJUNCTIVE DENTAL CARE

The following additional information is set forth in a letter from General Robinson:

This letter sets forth the criteria which must be met in order for dental care, per se, to be payable by the Government as adjunctive to medical or surgical treatment under the Dependents' Medical Care Program.

1. The patient must be hospitalized as an inpatient by a physician for a medical or surgical condition.

2. The charge physician and the dentist must agree that the dental care is expected to exert a beneficial therapeutic effect on the medical or surgical condition for which the patient is hospitalized.

The following dental procedures and treatment

are **not** authorized as adjunctive dental care under the Dependents' Medical Care Program:

1. Full or partial dentures;
2. Fixed or removable bridge work;
3. Restorative dentistry;
4. Orthodontia; and
5. Prolonged peridontal treatments.

The above criteria applies to the authorization of adjunctive dental care whether it be rendered by a dentist (DDS), a physician or surgeon.

Persons or institutions giving support to the patient, i.e., anesthesiology, physical examinations, diagnostic tests, hospital accommodations, etc., must have listed on the DA Form 1863 which they submit, the diagnosis for which the patient was hospitalized. Such diagnosis would not be dental, as dental care, per se, is not authorized either on an inpatient or outpatient status.

Upon receipt of a claim from a dentist for adjunctive dental care, the Office for Dependents' Medical Care will take action. The fiscal administrators in the area will be notified as to the name of the patient, the name and address of the dentist rendering care, and whether the claim was approved (or disapproved) for payment.

Claims involving adjunctive dental care submitted by physicians or hospitals should be processed by the appropriate fiscal administrator based upon the above criteria.

Dental care, other than that provided within the above criteria, is not considered to be included within the terminology of "complete obstetrical and maternity care" authorized under the program. Consequently, dental care rendered such patients must meet the above criteria for adjunctive dental care in order to be authorized for payment.

This letter is an elaboration but not a change of Section 5, paragraph 502 i, of the Joint Directive for Implementation of the Dependents' Medical Care Act (Public Law 569—84th Congress).

Today's Health Contest Brings Two Top Prizes to Ohio Auxiliaries

Woman's Auxiliary units in Ohio took two top prizes in the National contest for selling large numbers of subscriptions to *Today's Health.* Winners were announced and prizes awarded at the 1957 annual meeting of the Woman's Auxiliary to the American Medical Association in New York City.

First prize in Group I (membership of 1 to 35) went to Huron County, Mrs. T. H. Smith, New London, chairman.

First prize in Group III (76 to 100) was won by Clark County, Mrs. Donald Guyton, Springfield, chairman.

Do You Know? . . .

Dr. Marion A. Blankenhorn, emeritus professor of medicine, was conferred the honorary degree Doctor of Humane Letters by the University of Cincinnati.

* * *

Dr. Morton Hamburger, associate professor of medicine at the University of Cincinnati, recently made a month's lecture tour of European medical schools and research centers, where he had been invited to speak on antibiotics, particularly in relation to research being carried on at the College of Medicine. The tour included visits to centers at London, Munich, Turin, Vienna, Zurich, and Geneva.

* * *

The population of veterans in civil life increased by 360,000 from April 1, 1956 to April 1, 1957, according to a report from the Veterans Administration. The increase was from 22,291,000 to 22,651,000.

* * *

Ohio State University College of Medicine has received a continuation grant of $9,800 from the Sister Elizabeth Kenny Foundation. Under the program, directed by Dr. Ralph E. Worden, medical students receive additional clinical and research experience in physicial medicine and rehabilitation during their vacation quarters.

* * *

R. G. Paterson, Ph. D., for many years executive secretary of the Ohio Tuberculosis and Health Association, now residing at Tryon, N. C., was awarded the Will Ross Medal by the National Tuberculosis Association for outstanding and distinguished contribution to the TB control movement, being the sixth recipient of that honor.

* * *

Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, has been appointed a member of the Advisory Board of the Roswell Park Memorial Institute of the University of Buffalo School of Medicine, reportedly the first laboratory in the world devoted exclusively to the study of cancer.

* * *

Dr. Clayton S. Smith has retired as chairman of the Department of Physiological Chemistry and Pharmacology at Ohio State University, after 37 years of service. Dr. John B. Brown, director of the University's Institute of Nutrition and Food Technology, succeeds him.

* * *

The Alumni Association of Western Reserve University's School of Medicine elected the following officers at its July meeting: Dr. George R. Krause, president; Dr. Grace E. Haskin, first vice-president; Dr. Homer V. Weaver, second vice-president, and Dr. William L. Schlesinger, secretary-treasurer.

Medical Board Examinations . . .

Total of 403 Doctors of Medicine Apply for Licenses To Practice in Ohio: List of Questions Is Given; Limited Practitioners also Apply

THE State Medical Board of Ohio examined 403 doctors of medicine who are seeking licenses to practice in the state, during its examinations in Columbus June 13-15, Dr. H. M. Platter, secretary of the Board, reported. The Board also examined 62 graduates of osteopathic schools who are seeking to practice osteopathic medicine and surgery in the state.

In the limited practice branches, examinations were given to the following numbers of persons: Chiropodists, 20; mechanotherapists, 15; chiropractors, 56; masseurs, 34; cosmetic therapists, 6.

Results of the examinations were to be announced following a meeting of the Board on August 27.

Following are the examination questions given to doctors of medicine:

ANATOMY

1. (a) Name the three sutures which traverse the skull when viewed from above. (b) What is the bregma? (c) What is the lambda?
2. (a) Name five of the eight muscles of the thorax. (b) What is the action of two of them? (c) What is the innervation of three of them?
3. Describe the pulmonary artery and give its branches, course, and relations.
4. (a) Give the origin of the subclavian arteries. (b) Name the branches of the subclavian artery.
5. (a) Describe the origin of the 6th cranial nerve (abducent). (b) Through what orifice does it enter the orbit? (c) What does it supply?
6. The Brachial Plexus. Name it's—(a) Origin; (b) Roots; (c) Trunks; (d) Divisions; (e) Cords.
7. Describe the cardiac plexus (Plexus Cardiacus).
8. (a) Name the four coats which make the wall of the stomach. (b) Describe fully one of these coats.
9. Describe the pancreas.
10. The external part of the hemorrhoidal plexus is drained by what veins?

PHYSIOLOGY

1. What are the major physiological actions of the adrenal cortical steroids?
2. Discuss irritability as a physiological property of the heart.
3. Discuss the dietary requirements of the body for proteins—consider different situations.
4. Define briefly: (a) apnea; (b) vital capacity; (c) pulse pressure; (d) respiratory quotient; (e) ischemia; (f) macular vision; (g) hunger contraction; (h) achromatic vision; (i) peristalsis; (j) ectopic pacemaker.
5. Discuss the causes of edema and in what conditions are these found?
6. Discuss the mechanisms of external respiration.
7. Discuss the physiology of the pancreatic gland: (a) mechanics of secretion in digestion. (b) hormonal secretion and its mechanism.
8. Discuss sugar metabolism and tell what functions it serves. Define: (a) Glycogenase; (b) Glycogenesis; (c) Glycogenolysis; (d) Gluconeogenesis.
9. What is the role of the liver in fat metabolism? What influences the equilibrium of fat in the liver?
10. Discuss the absorption of neutral fats and cholesterol. Elaborate as to the entero-hepatic circulation of bile constituents.

BACTERIOLOGY

1. (a) What micro-organism is showing a special tendency to develop antibiotic resistant strains? (b) What kinds of infection are resulting?
2. (a) What fungus disease produces findings similar to those of tuberculosis? (b) What are the usual methods of diagnosis?
3. What diseases are commonly transmitted by contaminated water?
4. (a) What types of helminth infestation are apt to be encountered in this area? (b) How would you diagnose each?
5. What disease producing micro-organisms are frequently anerobic?

DIAGNOSIS

1. Discuss the helpful points in diagnosis that can be obtained from observation of peripheral vessels.
2. Enumerate the causes of asymmetrical edema.
3. Describe the hyperventilation syndrone.
4. Give the differential diagnosis of pain in the unbilical region due to irritants and that due to appendicitis.
5. Give the causes of pneumaturia (passage of gas per urethram). (b) What procedures would you use to establish the diagnosis?
6. Give the differential diagnosis of carcinoma, tuberculosis and syphilis of the tongue.
7. A 21 year old male athlete, weight 140 lbs., height 70 inches, while broadcasting the morning news, was taken acutely ill with sudden pain in the chest followed by more progressively severe dyspnea—enumerate the physical signs that would help you arrive at a diagnosis.
8. What are the causes of an irreduceable femoral swelling without impulse in the femoral triangle (Scarpa's Triangle)?
9. What findings should be noted upon digital examination through the anal canal?
10. A 64 year old female fell on the street, striking the occipital region of the skull. Given a history of momentary unconsciousness, blood pressure 170/100, pulse 96, respirations 22 per minute, temperature 98.4, x-ray of skull—negative. Thirty-six hours later, the patient was returned to the emergency room in a semi-comatose condition with history of vomiting for 6 hours, blood pressure 220/132, pulse 66, respiration 12 per minute, temperature 102° per rectum. Enumerate the probable causes and your procedure.

CHEMISTRY

1. What is meant by the term "hypochloremic alkalosis?
2. Discuss briefly any three (3) of the following: (a) creatinuria; (b) ferritin; (c) hexokinase; (d) ph of intestinal contents.
3. Outline the laboratory findings in Cushing's syndrome.
4. Give the range of normal N.P.N. concentration in whole blood (or serum) and indicate the range (N.P.N.) in renal insufficiency and in uremia.
5. Discuss gastric analysis from the standpoint of presence or absence of "free acid" in the gastric content—in a patient suspect for gastric ulcer. When is the histamine test indicated?

MATERIA MEDICA AND THERAPEUTICS

1. Give five safety generalities or rules you follow in prescribing medicines.
2. Outline your treatment of an unconscious child, 4 years of age, brought into the emergency room.
3. Give the mode of action of antiseptics.
4. Name two digestants and modes of action.
5. Give the mode of action of the parasympathomemitic drugs.
6. Outline treatment of extra renal uremia.
7. Give the treatment of first degree, complete and intraventricular heart block.
8. Give the pharmacological action of quinidine.
9. Give the treatment of a patient with Addison's disease and superimposed acid fast bacillus infection.
10. Give the treatment of snake bites.

PRACTICE

1. What is the management of angioneurotic edema?
2. What are the causes of pulmonary edema (Clinical forms)?
3. Outline the treatment of the different clinical forms of pulmonary edema.
4. Describe the clinical picture of arteriolar nephrosclerosis.
5. Describe the "Nephrotic Syndrome."
6. Outline the management of cerebral thrombosis.
7. Give the important factors in determining the types and care of diseases of the pancreas.
8. Give the treatment for bronchiogenic carcinoma.
9. Discuss the management of a case of menorrhagia functional uterine bleeding.

10. (a) How would you recognize a patient with Beriberi? (b) How would you treat the case?

PATHOLOGY

1. List in successive steps the gross anatomic changes resulting from mitral stenosis.
2. With regard to emphysema: (a) List the causes. (b) List the effects.
3. List five important causes of ascites.
4. List the important sites and types of damage in tertiary syphilis.
5. List the tumors which can give a positive Friedman test for pregnancy.
6. (a) List the common causes of amyloidosis. (b) List the common sites of secondary amyloidosis.
7. List the possible complications of blood transfusion.
8. List the five commonest sites of epidermoid carcinoma.
9. List five important causes of abnormal uterine bleeding.
10. List five causes of chronic kidney disease which is commonly bilateral and produces renal insufficiency.

OBSTETRICS AND GYNECOLOGY

1. List the indications for forceps application.
2. List the requirements for forceps application.
3. List the contra-indications for forceps application.
4. List the types, symptoms, diagnosis and treatment of placenta previa.
5. Name the muscles involved in a third degree tear of the perineal body.
6. A patient, aged 55, has been treating for the past three years for menopausal syndrome and rather suddenly starts with vaginal bleeding. List the possible causes, methods of diagnosis and treatment of same.
7. Patient, aged 8 - 10, complains of vaginal bleeding. List the possible causes and methods of diagnosis.
8. List the minimum requirements for pregnancy to take place in a presumably infertile couple.
9. Give differential diagnosis between carcinoma in situ and chronic endocervicitis and treatment of both conditions.
10. List the symptoms, diagnosis and treatment of choriocarcinoma.

SURGERY

1. List the symptoms, diagnosis and treatment of mesenteric thrombosis.
2. Simple fracture of both bones of the lower extremity (mid third) with one to two inches overlapping—describe treatment.
3. Name the arterial blood supply ligated intra-abdominally in doing a one stage abdomino-perineal resection of the rectum.
4. List the indications for thorocotomy.
5. Give symptoms, diagnosis and treatment of thyroglossal cyst.
6. Give differential diagnosis between acute coronary insufficiency and acute gall bladder in a patient aged 50 - 60.
7. Give symptoms, diagnosis and treatment of hypernephroma.
8. Give symptoms and treatment of hemorrhage from the middle menigeal artery.
9. Give symptoms, diagnosis and treatment of ulcerative colitis.
10. List the symptoms following injury to or division of the radial nerve in the forearm.

SPECIALTIES

1. Give the characteristic symptoms of acute glaucoma.
2. Compare nitrous oxide, chloroform and ether in general anaesthesia as to induction, area of usefulness and dangers.
3. Differentiate papilloma of the urinary bladder and stone in the urinary bladder.
4. Give the symptoms indicating acute coronary thrombosis (non-fatal) and outline a proper routine for the patient.
5. A two months old baby is brought to your office that is noticeably undernourished, constipated and bottle fed. Outline proper management, formula and directions to mother for the care of the child.

PREVENTIVE MEDICINE & HYGIENE

1. Differentiate measles, scarlet fever and shell-fish poisoning.
2. Name five diseases for which there is an acceptable method of immunization. Give time schedule with preferred ages for the immunization and length of time that immunity continues.
3. Give means of transmission and methods of protection against each of the following: (a) trichinosis; (b) uncinariasis; (c) undulant fever; (d) psitticosis; (e) tularemia.
4. When a physician makes a diagnosis of opthalmia neatorium in a patient, what are his responsibilities with respect to the public health problems involved?
5. Outline briefly the role of dusts in production of diseases of the lungs and give measures that should be instituted to prevent such diseases.

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

April 2, 1957—Paul David Millkin, Toledo, Yale University; Curtis Ramon Weathernogg, Columbus, University of Nebraska.

June 14—Charles John Amann, Cincinnati, St. Louis University; Claude Taylor Anderson, Cleveland, Yale University;

Winslow Jerome Bashe, Jr., Columbus, Loyola University; Joan Marie Baumgartner, Cleveland, Northwestern University; Faustino Bernadett, Toledo, University of Michigan; Jerrold Lee Berry, Toledo, University of Michigan; Charles Richard Blake, Columbus, Medical College of Virginia; Jerry Nelson Bosnak, Wooster, University of Pittsburgh; Richard Chadwick Britton, Cleveland, Yale University; George Emerson Brown, Cincinnati, University of Minnesota; Oswald G. Burkart, Jr., Tiffin, Loyola University;

Charles Lee Camp, Columbus, Medical College of Alabama; Kenneth Jones Chapman, Jr., Columbus, University of Tennessee; Arthur Lee Clark, Columbus, Howard University; Bruce Kendall Clark, Toledo, University of Michigan; Junius Edmund Cromartie, Jr., Meharry Medical College; George Clifton Curtis, III, Cincinnati Vanderbilt University; Edwin R. Davis, Jeffersonville, Univ. of Louisville; Stuart Melvin Denmark, Dayton, New York University; Paul S. Derian, Marion, University of Virginia; Simon Dorfman, Toledo, University of Vermont; David Clarence Dorr, Columbus, Johns Hopkins; Brewster Clark Doust, Jr., Akron, University of Rochester;

F. Kathryn Edwards, Cincinnati, Medical College of Georgia; William A. Erwin, Dayton, Univ. of Louisville; James Emmett Foerstner, Cleveland, St. Louis University; James McBrayer Garvey, Jr., Cincinnati, Columbia University; Edward Gerber, Jr., Marion, New York Medical College; Michel George Gilbert, Cleveland, New York University; Lowell Kenyon Good, Wayne University; Edward Anthony Gretchen, Morrow, St. Louis University; Amelia Gruber, Cleveland, Temple University; Andrew Meek Gulliford, Newark, University of Pittsburgh;

Richard DeLeon Handy, Jr., Youngstown; Meharry Medical College; Lynn Koehler Hawkins, Berlin Center, University of Pennsylvania; Virginia K. Hendricks, Toledo, University of Illinois; William McIntosh Hindman, Fremont, University of Tennessee; Harold Brinkley Hines, Cincinnati, University of North Carolina; William Henry Hoffman, Marion, Albany Medical College;

(Continued on Next Page)

Keith Randall Irish, Cleveland, University of Illinois;

Joseph Hifuo Iwano, Alliance, Washington University; Seaton James Jackson, Cleveland, Meharry Medical College; Robert Peter Johnson, Middletown, University of Illinois; Elwood Leroy Jones, Cincinnati, University of Kansas;

Henry Grace Kelley, Jr., Columbus, Medical College of South Carolina; Benjamin Kendall, Shaker Heights, Temple University; Kriss Miller Kerr, Cleveland, State University of Iowa; Odell Culp Kimbrell, Jr., Gallipolis, University of Pennsylvania; Elizabeth Korst-DeWitt, Cleveland, University of Georgia; Neal Edward Krupp, Lorain, St. Louis University;

Daniel Germain Lareau, Gallipolis, University of Vermont; Edward Bena Lazor, Lakewood, Northwestern University; Edward Braswell Leverich, Cleveland, Tulane University;

Frederic Maccabe, Jr., Dayton, University of Virginia; Jack Martin, Cincinnati, Vanderbilt University; Orlan Vincent Wade Masters, Akron, Stanford University; Francis Patrick McQuillan, Toledo, St. Louis University; Joseph Russell McWhirt, Dayton, George Washington University; Edgar Allen Miller, Jr., Cleveland, University of Maryland; Robert Arthur Milroy, Youngstown, University of Illinois; John Howard Morledge, Gibsonburg, Western Reserve University; William Jerome Mulally, Cleveland, St. Louis University; Robert Thomas Murphy, Cleveland, University of Michigan;

Thomas Erwin Nesper, Fremont, University of Michigan; Vernon Alfred Nichols, Marion, New York Medical College; Peter A. Overstreet, Toledo, University of Louisville; Donald Marvin Perlman, Cleveland, Boston University; Harold Perry, Cincinnati, Howard University; Ronald L. Peterson, Lima, Indiana University; Harold Clifford Pickering, Hahnemann Medical College; Stanley Post, Cleveland, New York State University;

Dean Gardner Robinson, Cleveland, Southwestern Medical School—Texas; John Jerome Roget, Belle Center, Indiana University; George Elson Ruff, Dayton, University of Pennsylvania; Daniel M. Romer, Dayton, St. Louis University; James D. Ruffner, Miamisburg, Univ. of Louisville; Maurice Boyd Ruland, Cleveland, Bowman Gray School of Medicine;

Nicholas B. Salistean, Youngstown, Univ. of Cluj, Romania; Rosemary Estelle Schmidt, Cincinnati, St. Louis University; Hilmer Gerard Siek, Jr., Columbia University; Ray Clayton Smith, Jr., Marion, College of Medical Evangelists; Jack Ellwood Steele, Dayton, Northwestern University; Robert Arnold Stewart, Columbus, Wayne State University; Harold Counsellor Stratton, Dayton, Howard University; Hubert Charles Swartout, Massillon, College of Medical Evangelists; Edward David Swiss, Columbus, Boston University; Robert Lee Tannenbaum, Cleveland, Chicago Medical School, Henry John Teufen, Jr., Cleveland, Jefferson Medical College; Walter Alvin Thomas, Columbus, Howard University; William James Thorpe, Cleveland, St. Louis University;

Joseph Wagner, Cleveland, University of Toronto; David Wallace, Cincinnati, Meharry Medical College; Gerard Alphonse Weigel, Dayton, St. Louis University; Roy Milton Whitman, Cincinnati, Indiana University; Coleman Boyd Witt, Dayton, Univ. of Louisville; Andrew Price Woolley, Jr., Worthington, College of Medical Evangelists; Paul Edward Wry, Youngstown, Georgetown Medical School; Jonathan Jerome Yobbagy, Steubenville, University of Pennsylvania; James Francis Zeller, New Philadelphia, University of Buffalo; Edward Joseph Zenni, Jr., Cincinnati, St. Louis University.

Ophthalmology Course at OSU Scheduled in March

A Postgraduate Course in Ophthalmology has been announced in the Department of Ophthalmology, Ohio State University, for March 3 and 4, 1958.

Guest speakers for the program will include Dr. F. Bruce Fralick, University of Michigan; Dr. Algernon B. Reese, New York City, and Dr. Charles L. Schepens, Boston, Mass. Also participating in the program will be the following members of the OSMA faculty: Dr. William H. Havener, Dr. Madge T. Macklin, Dr. Torrence A. Makley and Dr. William H. Saunders.

A program has been arranged for the ladies who wish to accompany their husbands.

Registration is $20. Registration or inquiries should be directed to: William H. Havener, M. D., Department of Ophthalmology, University Hospital, Columbus 10, Ohio.

Guy J. Clark Dies

Guy J. Clark, well known in the hospital administration field and for many years executive secretary of the Cleveland Hospital Council, died on July 2, at the age of 68. He was executive secretary of the Hospital Finance Corporation of the Cleveland area. Among offices he held were those as former president of the Ohio Hospital Association and as a director of the American Hospital Association. His widow and a daughter survive.

The *Columbus Dispatch* on June 30 ran a four-page feature article on Columbus as the third most important convention city in the nation. Featured in the article as typical of convention-goers were Dr. and Mrs. Charles H. McMullen, of Loudonville, who attended the Annual Meeting of the Ohio State Medical Association in the new Veterans Memorial Building. Dr. McMullen is president of the Ashland County Medical Society.

Two Named to State Medical Board . . .

Governor Appoints Dr. John D. Brumbaugh, Akron, and Dr. Frederick T. Merchant, Marion, to Fill Vacancies on State Licensing Agency

DR. JOHN D. BRUMBAUGH, Akron, and Dr. Frederick T. Merchant, Marion, have been appointed by Governor C. William O'Neill to membership on the State Medical Board and their appointments were confirmed by the Ohio Senate.

Dr. Brumbaugh succeeds Dr. Ralph W. Tapper, of Dayton, his term expiring in 1963. Dr. Merchant succeeds the late Dr. C. W. Waggoner, Toledo, his term expiring in 1964.

A native of Stark County, Ohio, Dr. Brumbaugh received his A. B. degree from Johns Hopkins University in 1920, held a Graselli Fellowship at Case Institute of Technology in 1921-22, and received his medical degree from The Ohio State University College of Medicine in 1927.

He practices in the eye, ear, nose and throat field, having been certified by the American Board of Otolaryngology in 1934, the American Board of Ophthalmology in 1935, and the International Board of Surgery, as related to ophthalmology and otolaryngology, in 1950. He was elected to the Society of Sigma Xi in 1922.

PROFESSIONAL AFFILIATIONS

Dr. Brumbaugh is a member and past president of the Summit County Medical Society, a member of the OSMA and AMA, a member and past president of the Summit County Chapter, American Association of Physicians and Surgeons, a fellow of the American Academy of Ophthalmology and Otolaryngology, the American College and International College of Surgeons.

Since 1933 he has practiced in Akron, following three years on the staff of the University of Pittsburgh Medical Center. He is a member of the senior staff of Akron City Hospital and The St. Thomas Hospital, and a member of the privileged staff of all other Akron area hospitals.

A veteran of both World War I and II, he is a member of the American Legion, served as president of LaFayette Chapter, Sons of the American Revolution, and is active in SAR on state and local levels.

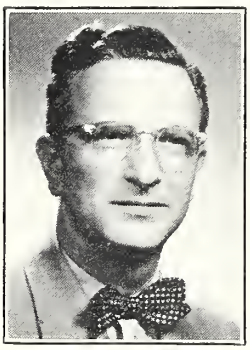
Dr. Brumbaugh was president of the Akron Kiwanis Club in 1956, a founder and long an active member of the Florence Crittenton Home Foundation; member, Society of the War of 1812; member, Akron Chamber of Commerce Board of Trustees, for a number of years was a trustee for Akron Hospital Service (Blue Cross) and just recently was appointed to the Board of Trustees of Blue Cross of Northeast Ohio, representing the medical profession.

DR. MERCHANT IS SURGEON

Dr. Merchant, a native of Marion, practices in the field of general surgery. He received his bachelor of arts from Ohio Wesleyan University in 1933 and his medical degree from Johns Hopkins University in 1937, followed by graduate



DR. BRUMBAUGH



DR. MERCHANT

studies in surgery and urology at Johns Hopkins Hospital in 1937-38, pathology at Royal Victoria Hospital, Montreal, Canada, in 1938-39, surgery at the University Hospitals of Cleveland in 1939-40, and resident surgeon at Royal Victoria Hospital in 1940-42. He was a member of the teaching faculty of medicine at McGill University in 1938-39 (pathology) and 1940-42 (surgery). Since 1946 he has practiced general surgery at Marion.

His professional memberships include the Marion Academy of Medicine, OSMA, AMA, Ohio Committee on Trauma and Ohio Chapter, American College of Surgeons; Ohio State Surgical Association, Cleveland Surgical Society, AAPS, Association of Military Surgeons, Association of New York Central Surgeons, AAAS, OSMA Committee on Hospital Relations, former member of OSMA Section on Surgery Committee, and is surgeon for the Marion District, New York Central System.

He is director and coordinator of the Marion General Hospital Disaster Plan, director of the Marion Cancer Detection Clinic, an executive member of the Rice Foundation for Premedical Education, OWU, was president-elect of the Marion Academy of Medicine (but could not serve due to military service in 1951), and is medical staff director and coordinator of records and

statistics at Marion General Hospital, as well as a member of the Marion City Board of Health.

He is a past president and former director of the Marion Chamber of Commerce and the Marion Country Club, former chairman of the Marion United Appeals, and in 1955 was vice chairman of the City Charter Commission. He is a member and former vestryman of the Marion St. Paul's Episcopal Church.

He is a diplomate of the American Board of Surgeons (since 1946), fellow, American College of Surgeons (1947), was elected to Phi Beta Kappa at OWU in 1932, has been listed in *Who's Who in the Midwest* since 1949, and in 1955 received a Civic Service Citation for his United Appeals leadership.

HOLDS LIEUTENANT COLONELCY

Dr. Merchant holds the rank of lieutenant colonel in the U. S. Army Reserve (Medical Corps), served in five campaigns in Europe during World War II, during which he was chief of surgical team, First Auxiliary Surgical Group, from 1942 to 1946. During the Korean War he was recalled to active duty as assistant chief, Surgical Consultants Division, Office of the Army Surgeon General, and in 1950-51 served as civilian consultant to that office. He is a past president, Marion Area Chapter, Reserve Officers Association, past surgeon, Ohio Department, ROA, and a member of the Ohio Section U. S. Army Advisory Committee.

Additional activities include membership in Phi Gamma Delta fraternity, OSU; Nu Sigma Nu, Johns Hopkins; Kiwanis Club, Marion Symposium Club, American Legion, associate member, Fraternal Order of Police, and Columbus University Club. In addition, he has had published professional articles in the *American Journal of Medical Science, Archives of Surgery, Surgery, Gynecology and Obstetrics*, as well as other publications.

He is a member of the staff and attending surgeon at Marion General Hospital, past chief of staff and surgery there; attending surgeon at the Upper Sandusky Wyandot Memorial Hospital and the Morrow County Hospital, Mount Gilead, and consulting surgeon, Sawyer Sanitorium, Marion.

Other members of the Medical Board include Dr. H. Karl Dimlich, Cleveland; Dr. J. N. McCann, Youngstown; Dr. J. O. Watson, D. O., Columbus; Dr. W. M. Hoyt, Hillsboro; Dr. Donald F. Bowers, Columbus. Dr. H. M. Platter, Columbus, is secretary of the Board.

An invitation has been issued to physicians by Dr. F. J. Pinkerton, director general of the Pan-Pacific Surgical Association, Room 230, Young Building, Honolulu, Hawaii, to attend the seventh congress of that organization in Honolulu, November 14-22. Details may be obtained by writing.

VA Makes Policy Change On Handling W. C. Cases

Following up its May 29 order to Veterans Administration hospitals, the VA on June 26 formally announced to the public that patients in non-service-connected cases covered by workmen's compensation or similar accident insurance will be asked to move from VA hospitals when their conditions warrant. But no veteran will be transferred or discharged until his right to necessary treatment elsewhere at no expense to himself has been clearly established, VA said.

The order applies only to veterans who do not have a service-connected disability and are admitted for occupational injuries or diseases incurred in or as a result of their employment. Since most veterans brought to VA hospitals for on-the-job injuries are emergency cases, the extent of industrial accident insurance usually can't be determined until after admission, VA said.

Once this is determined, the veteran will be asked to reconsider his statement of inability to pay and to agree to a transfer. A veteran refusing in these circumstances will have his file sent to Washington for review and possible referral to the Justice Department for prosecution.

New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since June 1, 1957. The list shows the County in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

CUYAHOGA COUNTY

Andrius J. Bridzius, Cleveland
Robert H. Ebert, Cleveland
Joseph O. Fikar, Cleveland
Julius Fishman, Cleveland
William M. Hall, Cleveland
Robert H. Jackson, Westlake
Nachman Kacen, Cleveland
Dieter Koch-Weser, Cleveland
John D. Petcher, Cleveland
Raymond E. Weigel, Cleveland
Oscar Wilhelmy, Cleveland

FRANKLIN COUNTY

Conrad E. Albrecht, Columbus
Robert E. Batterson, Columbus
Ralph E. Brown, Jr., Columbus
Gail E. Burrier, Canal Winchester
Kenneth J. Chapman, Jr., Columbus
John F. Condon, Columbus
James M. Coulter, Columbus
Francis W. Eberly, Columbus
Miles A. Erickson, Columbus
Walter D. Hofmann, Columbus
Richard J. Lescoe, Columbus
John N. Meagher, Columbus
Jorge Medina, Columbus
James G. Morgan, Columbus
Thomas C. Pomeroy, Columbus
Andrew J. Pultz, Columbus
John R. Titus, Springfield
Charles R. Wilcox, Columbus
Kurt Witton, Columbus

HAMILTON COUNTY

Leonard A. Burgin, Cincinnati

LORAIN COUNTY

Tamas Lanczy, Grafton

MAHONING COUNTY

Edward J. Gluck, Youngstown

SUMMIT COUNTY

Harold E. Reed, Akron

TUSCARAWAS COUNTY

James Bates, Dover

Ohio Academy of General Practice . . .

Program Is Announced for the Annual Scientific Assembly To Be Held At the Veterans Memorial Building in Columbus. September 18 and 19

THE Ohio Academy of General Practice will hold its Seventh Annual Scientific Assembly in Columbus on Wednesday and Thursday, September 18 and 19. All scientific programs, including the exhibits, will be in the Veterans Memorial Building, 300 West Broad Street. Postgraduate credit for members of the American Academy of General Practice is 12 hours.

The program has been announced as follows:

WEDNESDAY, SEPTEMBER 18

(All time is Eastern Standard)

8:00 A. M.—Registration and Visit of Exhibits.
8:45 —Addresses of Welcome.
9:00 - 9:45—**Current Problems in the Treatment of Infection**, Dr. Morton Hamburger, Cincinnati.
9:45 - 10:30—**The Art of Treatment with Tranquilizing Drugs**, Dr. Frank J. Ayd, Jr., Baltimore, Md.
10:30 - 11:15—Visit to Exhibits.
11:15 - 12:00—**Rehabilitation of the Hemiplegic Patient**, Dr. Paul A. Nelson, Cleveland.
Lunch and Visit to Exhibits.
1:30 - 2:15 P. M.—**Cervical Biopsies in Office Practice**, Dr. Malcolm L. Barnes, and Dr. George S. Allen, Louisville, Ky.
2:15 - 3:00—Visit to Exhibits.
3:00 - 3:45—**The Allergic Patient, His Problems, Office Diagnosis and Treatment**, (Emphasis on Bronchial Asthma), Dr. Nathan E. Silbert, Lynn, Mass.
3:45 - 4:30—**Intra-Articular and Peri-Articular Injections with Hydrocortisone in the Office**, Dr. J. I. Kendrick, Cleveland.
Banquet—**Both Doctors and Patients Are Human Beings**, Dr. Edward H. Rynearson, Rochester, Minn.

THURSDAY, SEPTEMBER 19

8:00 A. M.—Registration and Visit to Exhibits.
9:00 - 9:45—**Athletic Injuries**, Dr. Richard Patton, Columbus.
9:45 - 10:30—**The Irritable Child**, James L. Dennis, Oakland, Calif.
10:30 - 11:15—Visit to Exhibits.
11:15 - 12:00—**New Methods for the Treatment of the Arteriosclerotic Heart**, Dr. Walter L. George, Cleveland.
Lunch and Visit to Exhibits.
1:30 - 2:15 P. M.—**Gynecological Disease in Adolescents and Children**, Dr. Edward Allen, Chicago.
2:15 - 3:00—Visit to Exhibits.
3:00 - 3:45—**Cosmetic Dental Problems in the Growing Child**, Dr. John E. Aldrich (D. D. S.), Columbus.
3:45 - 4:30—**Behavior Problems in Adolescent Children**, Dr. Louis J. Wise, Cincinnati.

American College of Chest Physicians Names Ohioans as Fellows

The following Ohio physicians received certificates of Fellowship in the American College of Chest Physicians at the convocation in New York on June 1: Drs. Paul Bell, Toledo; Frederick S. Cross, Cleveland; Harold I. Humphrey, Columbus; Walter Kasserman, Canton; Frederick R. Mautz, Cleveland; F. Mason Sones, Jr., Cleveland; M. Paul Thomas, Cleveland, and Joseph F. Tomashefski, Columbus.

Nearly $10-Million Daily of Nation's Health Bill Paid by Insurance

More than $3-billion—a rate of nearly $10-million per day—of the nation's health care bill will be paid in 1957 through voluntary health insurance programs, according to the Health Insurance Council.

This estimate was made by the Council based on the results of its annual survey of health insurance coverage in the United States for 1956. Benefit payments to help cover the cost of hospital, surgical, and medical care last year amounted to $2.9-billion, an all-time high.

The Council, in a projection of its 1956 figures on health insurance coverage in the United States estimates that as of May 1, 1957, some 118-million persons were protected against the cost of hospital expenses through voluntary health insurance programs, 103-million were covered for surgical expenses, 67-million had policies covering regular medical expenses, and 10-million were insured against major medical expenses. These figures, added the Council, mean that over 70 per cent of the total U. S. civilian population today is protected by some form of voluntary health coverage.

The traditional New York Academy of Medicine's Graduate Fortnight has been contracted this year to a Postgraduate Week of five days—October 7-11. The theme is "Research Contributions to Clinical Practice." Details may be obtained by writing the academy at 2 East 103 St., New York 29, N. Y.

Revised VD Treatment Schedule . . .

Latest Knowledge in Regard to Venereal Disease Incorporated in Revised Treatment Schedule Recommended by Department of Health

THE OHIO Department of Health has recently revised its recommended venereal disease treatment schedule, commensurate with the latest knowledge in the field and the efficacy of various therapeutic agents used in their treatment. Dr. Frederick H. Wentworth, Chief of the Division of Communicable Diseases of the Ohio Department of Health, has requested *The Journal* to publish the new schedule for the benefit of Ohio physicians. The schedule also is available through local health departments.

In announcing the schedule, Dr. Wentworth emphasized that the information is being presented for the benefit of practitioners who wish a standard upon which to base their therapeutic schedules. Many physicians prefer a regimen of treatment of their own, he said.

The following statement was published by the Division of Communicable Diseases with the schedule:

USUAL SEROLOGICAL REACTIONS IN SYPHILIS FOLLOWING ADEQUATE TREATMENT

As of the present, adequate treatment for syphilis consists of 4,800,000 to 7,200,000 units procaine penicillin in oil with aluminum monostearate (PAM) or 2,400,000 to 7,200,000 units of benzathine penicillin G (long-acting penicillin preparations).

The serologic evaluation of treatment response probably constitutes one of the major difficulties to practitioners concerned with the treatment of syphilis.

Authorities agree that the longer the individual has had the disease, the longer seroreversal will take, however, each patient must be considered as an individual case. There are certain guides which may be of assistance:

In seroreactive primary or secondary syphilis the serological test for syphilis usually shows a quantitative decrease (significant drop in dilutions) within six months after adequate treatment. Complete sero-nonreactivity may not be obtained for as long as one to two years or more after treatment, depending upon serologic technic used.

Following adequate treatment for early latent syphilis of from two to four years duration, it is not usual for patients to remain seroreactive much beyond two years. Added treatment **will not** change the blood test.

If treatment has not been given until latency, seroreversal is much slower, so that in late latent syphilis approximately half of the patients may be expected **never** to attain nonreactivity. Persistence of reactive serological tests after adequate treatment does not necessarily mean a continuation of the infection.

Treatment for the sole purpose of obtaining a nonreactive serological test for syphilis is expensive, worrisome and cannot be considered sound practice.

Good results in the treatment of neurosyphilis and cardiovascular syphilis can be expected with total doses of 6,000,000 to 7,200,000 units of PAM. The main purpose of therapy is to heal active lesions, thus preventing further progress of the disease. **The reactive blood test does not indicate the amount of healing in late syphilis.**

In pregnancy, where adequate treatment has been given previously, no retreatment is necessary for each succeeding pregnancy unless there is evidence of serorelapse, reinfection or a definite increase of serological dilutions (dils) from former levels.

Persistent reactive serological tests are not an indication for retreatment, provided the titers fall to relatively low levels within the first six months after treatment. A repeat course of adequate treatment should be considered when:

(1) symptoms develop which can be attributed to syphilis reinfection or relapse;
(2) a sustained increase in serological titer of four-fold or greater develops;
(3) exposure to known infectious syphilis occurs—prophylactic treatment;
(4) failure of the spinal fluid cell count to revert to normal (less than five cells) one or two years post-treatment.

Penicillin-Sensitive Patients with a reactive serological test for syphilis can be treated with three Gm. daily of Erythomycin, Carbomycin, or one of the tetracycline compounds (such as Mysteclin) for ten days for latent syphilis; fifteen days for neurosyphilis or cardiovascular syphilis.

(See Treatment Schedule on facing page.)

Role of Radiologist

A new color motion picture added to the AMA's Film Library and entitled "First A Physician" tells the story of what a radiologist is, what he does and how he serves patients. The film was produced by E. I. du Pont de Nemours & Co., Inc., in cooperation with the American College of Radiology. Medical Societies may arrange for bookings through the Film Library. The film will be particularly suitable for school, club and other public gatherings.

Venereal Disease Treatment Schedule

Recommended by the Ohio Department of Health, 1957

SYPHILIS

Any one of the following schedules may be considered adequate treatment. The choice of drug will depend upon the physician's preference for the individual case.

Primary **Secondary** **Latent (Early and Late)**	**Benzathine penicillin G** (long-acting penicillin preparations such as: Bicillin, Permapen, and Durycin) 2,400,000 units. (One treatment of 1,200,000 units (4cc) in each buttock—dividing the dose reduces the pain)
***Congenital (Early) (2-10 years of age)**	**Procaine penicillin** in oil with aluminum monostearate (PAM) 4,800,000 units. (Four treatments of 1,200,000 units (4cc) at intervals of 2 to 7 days)
Neurosyphilis **Cardiovascular** **Congenital (Late) (Over 10 years of age)**	**Aqueous procaine penicillin**—6,000,000 units. (Daily treatments of 600,000 units (2cc) for 10 days)
Treatment Failures	**Benzathine penicillin G** (long-acting penicillin preparations) 7,200,000 units. (Three treatments of 2,400,000 units at 2 to 4 day intervals but no more than a 7 day interval—the purpose being that increased concentrations are preferred over prolonged duration of therapy)
	Procaine Penicillin in oil with aluminum monostearate (PAM) 7,200,000 units. Six treatments of 1,200,000 units (4cc) at intervals of 2 to 7 days)
	Aqueous procaine penicillin—9,000,000 units. (Daily treatments of 600,000 units (2cc) for 15 days)

*Congenital syphilis in children under two years of age should be treated with either PAM or long-acting penicillin preparations, 1,200,000 units. (Four treatments of 300,000 units (1cc) at 2 to 7 day intervals)

Note: All cases of Infectious Syphilis should be interviewed for contacts. All contacts who have no evidence of having acquired syphilis should be treated prophylactically with 1,200,000 units (4cc) of PAM or long-acting penicillin preparations in a single dose.

GONORRHEA

Female: All cases of female gonorrhea and female contacts to male gonorrhea cases should be treated with 1,800,000 units of **procaine penicillin** in oil with aluminum monostearate (PAM) (single dosage—900,000 units (3cc) each buttock) or long-acting penicillin preparations, 1,200,000 units, **even though there is no clinical evidence of infection.**

Smears and cultures have not been found dependable for the routine diagnosis of gonorrhea in females.

A blood specimen for a serological test for syphilis (STS) should be taken at time of first visit. There is evidence that the amount of treatment recommended here will control a syphilitic infection received during the gonorrhea exposure.

Routine interviews of female gonorrhea cases for contacts have not been found to be worthwhile.

Males: Single treatment of 1,200,000 units (4cc) of **procaine penicillin** in oil with aluminum monostearate (PAM) or long-acting penicillin preparations. It is recommended that males infected with gonorrhea (clinical and laboratory diagnosed) be interviewed for sexual exposures during the 7 to 10 days prior to appearance of symptoms. A blood test should be taken at time of first visit.

Treatment should not be considered complete until investigation as to source and spread is undertaken. Investigative assistance can be secured from the local health department or the Ohio Department of Health. Drugs are also available to the physician, upon request, for the treatment of indigent syphilitics.

Aid for Aged . . .

State Association Council Will Confer with State Agency Officials on Situation Resulting from Reduction in Medical Fees and Allowances

THE Officers and Council of the Ohio State Medical Association will confer with officials of the Division of Aid for the Aged of the Ohio Department of Welfare, September 14, concerning problems involved in the recent reduction of medical fees under the Health Care Program of the Division. The situation will be analyzed and possible solutions will be discussed.

As announced in the July issue of *The Ohio State Medical Journal*, revisions in policies and drastic cuts in the schedules of fees and allowances for medical, hospital and other services became effective July 1, due to the fact that funds appropriated by the 102nd Ohio General Assembly were not sufficient to meet the estimated costs of the program for the biennium starting July 1, 1957, and ending June 30, 1959. Approximately $29-million was requested for all health care items and the Legislature granted $18-million.

Starting July 1, 1956, the Division of Aid for the Aged medical-health program began functioning without the $200 limitation per case per year, which was removed by the Legislature in 1955. Although figures are not complete, the spending for health care for the first 12 months without the ceiling (July 1, 1956 to June 30, 1957) amounted to about $8-million and it was pointed out that bills will continue to come in for some time. This compared with about $3,300,000 spent by the Division of Aid for the Aged on this item in the previous fiscal year. In addition, county welfare departments that year furnished about $2,700,000. With the passage of H. B. 592 these local supplementary payments ceased.

Percentagewise, expenditures for the past fiscal year were approximately 59 per cent for hospital care; 25 per cent for medical; 20 per cent for nursing; and 5 per cent for all other.

A significant figure, however, is the "rate of expenditure" which was occurring as the fiscal year ended June 30, 1957. The program was getting into "high gear," and Division officials estimate that to continue operating at that level for the succeeding 12 months would require about $13½-million not counting the $3-million item which was requested for chronic hospital care. The amount appropriated by the Legislature for that period was $9-million.

NUMBER ON ROLLS

As of June 30, 1957, there were 94,539 recipients of aid for the aged. Their average age was 79. They were receiving assistance payments averaging $58.34 a month, not counting the health care item. Assistance payments vary with individual needs up to a maximum allowance of $65 a month.

The number of recipients has been dropping steadily since 1950 when there were 125,745 people on the list. A previous high occurred in 1942 when there were 139,282.

This decline has been attributed to the fact that an increasing number of elderly people are getting Old Age and Survivors Insurance, or "social security" benefits.

Comprehensive information concerning cuts in medical fees and allowances was published in the July *Journal*. Details concerning reductions in other services have now been secured.

HOSPITALIZATION

With regard to hospitalization, the Division will make available a sum sufficient to pay for hospital care for a period not to exceed 10 days during any one period of hospitalization. Formerly there was no restriction on the number of days.

The schedule for the chiropodists was the same as that for medical doctors and was reduced to the same extent. The patient must be referred to the chiropodist by a physician.

Previous to July 1, druggists were paid their regular price for drugs prescribed by a physician. Under the new setup they will be paid in accordance with the amounts listed in the Veterans Administration prescription schedule. The patient will be required to pay for any drug costing $2 or less, whereas, the tab for these small purchases was picked up by the Division before July 1.

The only treatment which can now be given by the dentist without prior authorization is emergency care for treatment of pain.

With regard to dentures, which have always been on a prior authorization basis, no artificial dentures will be authorized to anyone who has been without teeth and without artificial dentures for a period of 2 years.

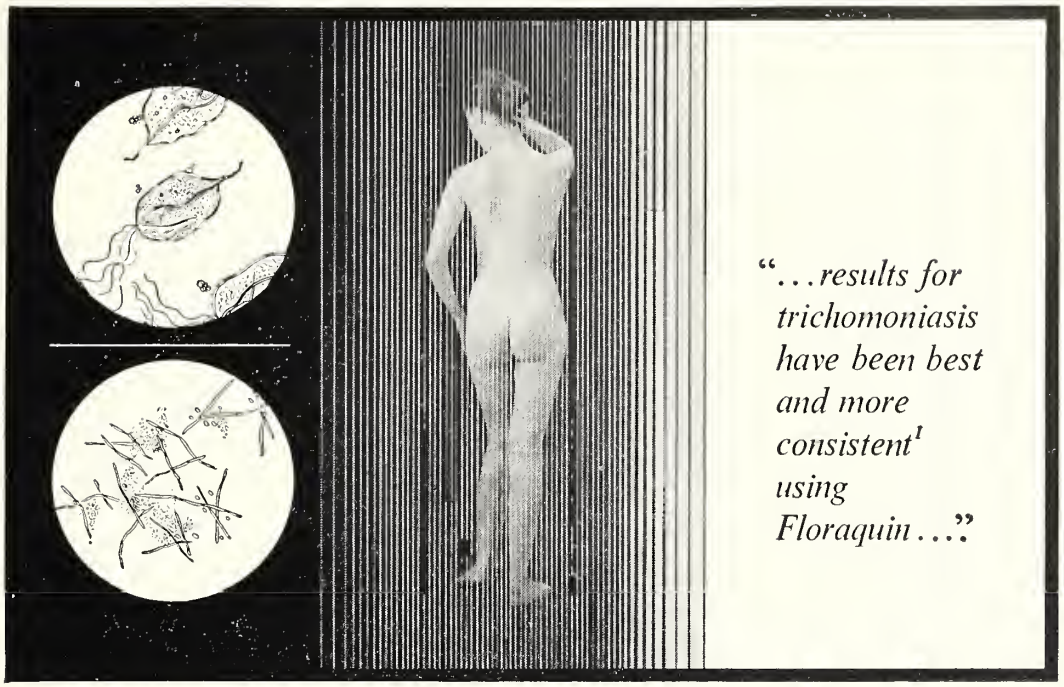
Partial dentures will be authorized only when necessary to provide a chewing surface and when cost is not more than for whole dentures.

Formerly $15 was paid for examination of the eyes and fitting of glasses. This fee has been reduced to $10. The Division will continue to pay only the catalog price on lenses and frames, but a ceiling of $6 has been set on the allowance for frames as of July 1.

NURSING CARE

In reference to nursing care in the home of a patient with a short term illness, such care may

EFFECTIVE, DEPENDABLE THERAPY FOR VAGINITIS



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Floraquin® eliminates trichomonal and mycotic infection; restores normal vaginal acidity

Leukorrhea is by far the most frequent symptom of vaginitis; trichomonads and monilia are the most common causes. Many authors have reported[2] trichomonal protozoa in the vagina of 25 per cent of obstetric and gynecologic patients. Increased use of broad spectrum antibiotics has resulted in a sharp rise in the incidence of monilial infections.

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Pitt[1] recommends vaginal insufflation of Floraquin powder daily for three to five days, followed by acid douches and the daily insertion of Floraquin vaginal tablets throughout one or two menstrual cycles. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

1. Pitt, M. B.: Leukorrhea. Causes and Management, J. M. A. Alabama 25:182 (Feb.) 1956.
2. Parker, R. T.; Jones, C. P., and Thomas, W. L.: Pruritus Vulvae, North Carolina M. J. *16*:570 (Dec.) 1955.

SEARLE

be furnished by a registered nurse or licensed practical nurse on the order of a physician when the cost is reasonably less than the cost of hospital care.

A "freeze" has been instituted on allowances for care in nursing homes wherein the amount paid monthly for care in nursing homes in each county is limited to the amount spent in the given county during June, 1957.

With regard to long term nursing care in the patient's home, this will be allowed on the same quota basis as above if it costs no more than the maximum nursing home rate in the community.

Six million dollars of the amount requested for health care during the biennium was to provide for payment of chronic hospital care for the next two years. However, since this item was not granted, this service cannot receive funds from the Aid for the Aged program.

Department of Welfare officials do not visualize any change in the fee schedules of the other medical programs of the Department using the Aid for Aged Medical and Surgical Fee Schedule, namely, the Services for Crippled Children, and the Vocational Rehabilitation Services for the Blind.

LETTER EXPLAINS POLICY

The following letter explaining health care reductions was sent by Mrs. R. L. Ireland, director of the Department of Welfare, to all relief directors, on July 11, 1957:

"Knowing your interest and deep concern in the recent changes in the administration of the Aid for the Aged Health Care Program, we felt that you would want to know exactly what was done and why it was done.

"The appropriations available to the Division of Aid for the Aged for health care of recipients for each year of the biennium starting July 1, 1957, are about $3-million per year less than the current rate of expenditure. (EDITOR'S NOTE: This does not include the approximately $3-million a year requested for chronic hospital care.) Under the Aid for the Aged law, additional payments for health care beyond the $65 maximum monthly grants are required to be maintained within available appropriations. Therefore, it has been necessary to effect a revision of the Aid for the Aged Health Care Program so that expenditures will be held at a level which will not exceed the appropriated funds.

"Consequently, this Department has approved recommendations for revisions of payments for hospital and medical care as well as for all other kinds of health care. In hospital care, the amount which the Division of Aid for the Aged can pay on behalf of a recipient has been limited to ten days of hospitalization. Similarly, the payments which can be made to doctors in medical care cases have been limited to payment for two calls per month in chronic cases and ten calls per month in acute cases.

"Under these circumstances, additional need may exist in some instances, which need could be filled by the local welfare agencies through supplementations pursuant to the authority granted such agencies under Sections 5113.01, et seq., Revised Code. Where funds are available, the local welfare offices are urged to provide such supplementations.

"If you desire any further information concerning these revisions, please do not hesitate to call on us."

Very truly yours,
Margaret A. Ireland
Director.

Grant Promotes Psychiatric Studies at OSU

Receipt of seven U. S. Public Health Service research grants totaling more than $400,000 was announced by Dr. Ralph Patterson, medical director of the Columbus Psychiatric Institute and Hospital at the Ohio State University Health Center.

Administered through the National Institutes of Health, Bethesda, Md., the grants will support studies to be carried out by the research division of the psychiatric institute, directed by Dr. Benjamin Pasamanick.

The projects, of one to five years' duration, are concerned with prenatal precursors of neuropsychiatric disorder, biosynthesis of neuraminic acid, aging, drug effects on normal individuals, development of primate behavior, infantile experience, effects of brain damage, and vector and topographic electroencephalography.

Michigan To Hold Annual Meeting In Grand Rapids, Sept. 25-27

Ohio physicians, especially those in the northeastern areas of the state, are invited to attend the Michigan State Medical Society's Annual Session in Grand Rapids, September 25-27.

Among Ohio physicians who will participate is Dr. Leon Goldman, Cincinnati. Dr. John D. Porterfield, recently director of the Ohio Department of Mental Hygiene and Correction, and now with the USPHS Surgeon General's office, also is on the program.

Details may be obtained by writing: Michigan State Medical Society, 606 Townsend Street, Lansing 15, Mich.

Dr. Peter A. Volpe, administrator of the Ohio State University Health Center, was given the Achievement Award for 1957 by the Association for Physical and Mental Rehabilitation at ceremonies in Chicago, cited for his own rehabilitation and for his "inspiration to all." Dr. Volpe was the victim of a mine blast while serving as executive officer of the 76th Armored Medical Battalion during World War II.

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"NTZ . . . singularly effective for nasal congestion due to either allergic or infectious causes."

Levin, S.J.: *Pediat. Clin. North America* 1:975, Nov., 1954.

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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems: Suggestions Regarding Organized Activities

RULES, REGULATIONS AND CONTROLS

In the address on June 4 which he made when taking the oath of office as president of the American Medical Association, Dr. David B. Allman made this observation, among others, which is supported by so much substantial evidence that it simply cannot be refuted:

Commenting on why the doctor is fundamentally conservative, Dr. Allman said:

"In medicine, for example, he knows that first rate medical care—including humane consideration for the problems of the individual—cannot survive if patients and physicians are shackled by rules, regulations, controls and assembly-line procedures."

Dr. Allman could have added that rules, regulations, controls and assembly-line procedures are inherent in all third-party-administered medical programs and when a physician participates in such programs by becoming a vendor of services and the recipient of fees at the expense of the third-party, he should not delude himself into believing that he will be able to provide services unhampered by rules, regulations and controls.

Unfortunately, some physicians have the impression that this situation does not prevail. They get very much disturbed when the controls begin to pinch. They are failing to look at and understand the cold facts. When the physician accepts the fee, he automatically accepts the controls. There is no alternative.

PLENTY OF TALK BUT CHANCES FOR REAL CHANGE QUITE DIM

You probably read in the newspapers of the big talk of the governors at their annual conference about wanting the U. S. to give up a lot of the control it now has over the states through its taxing power and grants-in-aid programs.

Also, you may have read that Eisenhower has suggested a reshuffling of federal-state functions to give the states a better break on taxes and administrative authority.

Don't hold your breath until these reforms are achieved. These may be fond hopes but chances for any substantial improvement would appear to be mighty dim. Why?

Well, most of the governors would rather accept Federal handouts than raise state taxes to meet the costs of new state services and program which U. S. is now financing or has expressed a willingness to finance.

Second: Eight states, including Ohio, provide about 60 per cent of total personal income tax paid. Most of the states get more back from the Federal Government in the form of grants-in-aid in proportion to what they pay in than the few states, like Ohio, which carry the bigger load. The majority of the states, therefore, like the present system pretty well.

Round and round she goes, where she stops nobody knows.

IS IT ETHICAL OR UNETHICAL?

Among the compilation of questions and answers on matters of ethics which has been prepared by the Judicial Council of the AMA appears the following:

Question: Is it ethical for a physician to indicate on his letter or billhead, or his professional cards, that he is a member or fellow or diplomate of some specialty organization within the medical profession?

Answer: The physician should limit the use of statements of qualifications and honors on letter and billheads and professional cards to the simple, dignified abbreviation, "M. D.," or the statement "Doctor of Medicine." To do more smacks of self-laudation, borders on solicitation of patients, and tends to reduce the degree and title "Doctor of Medicine" to secondary importance. While it cannot be concluded that it is unethical to use specialty designations in this manner, it can be said that the practice is not in the best of taste or in the best interest of the profession.

From time to time we will publish excerpts like the above for the information and enlightenment of members of the Association.

CONTINUOUS SUPERVISION IS MOST EFFECTIVE PLAN

A new program endorsing periodic health appraisal for children sponsored by the National Congress of Parents and Teachers has won support of the AMA's Council on Medical Service. At a recent meeting, the Council voted to approve the following resolution:

"The Committee on Maternal and Child Care of the Council on Medical Service, AMA, reaffirms its approval of the principle of continuous health supervision of children from birth through their school experience rather than only a program of a single appraisal on school entrance. It also recommends that, where possible, this should be done by the physician and dentist who normally serve that child and family,

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HANDY, PLASTIC DROPPER BOTTLE
accurate dosage is easy, one drop per
pound body weight per day

SUPPLIED:
10 cc. plastic dropper-type bottle
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Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, N. Y.

preferably his personal physician and dentist. The Committee welcomes the support of the National Congress of Parents and Teachers."

This policy is in accord with that of the Ohio State Medical Association and its Committee on School Health. Local medical societies and their committees on school health should emphasize these principles in conferences with the PTA and local school officials.

BETTER DISCUSS THIS WITH YOUR INSURANCE ADVISER

U. S. Tax Court rendered a decision recently in a case involving a physician which decision probably will be of interest to other physicians—at least they should have their insurance representative look into the situation for them.

The Tax Court said that disability insurance premiums do not qualify as a business expense and are therefore not deductible.

The doctor took out three policies which were to pay him specified amounts if he became disabled or ill. He intended to use funds to pay his office expenses, but was not bound to do so.

The Tax Court held that the policies were designed to compensate doctor for a disability and not to reimburse him for business overhead expenses during disability; were personal in nature; premiums were not ordinary and necessary business expenses; doctor's intention to use proceeds to pay such expenses did not mean that they had to be used for that; disability policies cover loss of earnings and can be applied toward living expenses as well as anything else that the taxpayer wants.

It is presumed that the premiums would be deductible if the terms of the policy would limit application of the proceeds to payment of business expenses—in other words business overhead expense insurance.

Something worth discussing with your insurance adviser.

HERE'S GOOD WAY FOR COUNTY SOCIETY TO GRADE ITSELF

County medical societies will find excellent opportunity to give themselves a thorough self-examination by means of an AMA survey questionnaire mailed out in June.

AMA uses information obtained by the questionnaire to keep abreast of county activities, to learn of special activities and to let other medical societies know what their counterparts are doing.

But the questionnaire, while not circulated to do so, could well be used by the local society to evaluate its own programs and activities, to find potential avenues of activity and to strengthen apparent weak spots within the organization.

The questionnaire asks information concerning the frequency of and attendance at meetings, allocation of time to various subjects, topics that appear to be most popular—and least popular.

Further, it delves into the types of committees each local society has, covers programs and activities such as emergency call service, telephone answering service, how complaints are handled, medical economics, medical services and assistance plans.

Also, the questionnaire covers public relations and public information programs, participation of the society in community affairs and projects, indoctrination of new members, cooperation with medical assistants and associates, auxiliary cooperation, insurance, programs, dues, office facilities, and personnel.

While it is certainly not to be expected that every county medical society in Ohio be able to report affirmatively on every activity covered by the questionnaire, it is most probable that many societies could develop ideas and activities from the information requested.

POPULATION INCREASE CHALLENGES MEDICINE

By the time of the 1960 Census, statisticians estimate that the United States Population will be 178½-million persons, an increase of 27⅓-million over the 1950 figure.

This 10-year growth represents a 40 per cent increase over the 1940-50 increase, and should command significant attention of the medical profession.

More population means more demand for goods and services, and the demand for medical services is no exception. Americans are becoming more and more aware that good health is a good investment, that good health can be achieved and assured by modern medicine, and that the answer to the question of finding cures for unfathomed diseases can be obtained through medical research.

This booming growth offers a challenge to all members of the medical profession, be they in private practice, teaching or research.

NAME IS NEW BUT SAME VALUABLE SERVICE

The name of the American Medical Association's Council on Pharmacy and Chemistry has been changed to the Council on Drugs. Purpose of the change is to emphasize the Council's basic function, namely, to evaluate available evidence for the clinical application of all new drugs.

The Council also has adopted *New and Nonofficial Drugs* as the title to supersede the old name of its well known publication, *New and Nonofficial Remedies.*

New name or old, this important activity and publication represent one of the many valuable functions of the American Medical Association.

Iowa Settlement . . .

Agreement Between Physicians and Hospitals that Grew Out of Court Test of Corporate Practice Is Implemented by Legislative Statute

THE GENERAL ASSEMBLY OF IOWA recently enacted into law the settlement reached earlier between physicians and hospitals in that state in regard to the practice of pathology and radiology in hospitals. (Refer to January issue of *The Journal*, page 97.) Since this legislation is an important link in the field of physician-hospital relations in regard to corporate practice it is reproduced here in full.

A dispute between physicians and hospitals arose over an opinion of the Attorney General of Iowa given in 1954 in regard to corporate practice. Representatives of hospitals appealed to the district court which upheld the Attorney General. Appeal was then taken to the higher court, but pending the appeal settlement was reached between the Iowa State Medical Society and the Iowa Hospital Association. The recent legislative action implements the settlement and gives it legal status in that state.

THE ACT

Following is the legislative act, House File 21, "An Act Relating to Pathology and Radiology Services in Hospitals":

Be It Enacted by the General Assembly of the State of Iowa:

Section 1. This Act may be cited as the "Pathology and Radiology Services in Hospitals Act."

Sec. 2. Definitions as used in this Act:

(a) "Hospital" shall mean all hospitals licensed under chapter one hundred thirty-five B (135B) of the Code.

(b) "Doctor" shall mean any person licensed to practice medicine and surgery or osteopathy or osteopathy and surgery in this state.

(c) "Technician" shall mean technologist as well.

(d) "Joint conference committee" shall mean the joint conference committee as required by the joint commission on accreditation of hospitals or, in a hospital having no such committee, a similar committee, an equal number of which shall be members of the medical staff selected by the staff and an equal number of which shall be selected by the governing board of the hospital.

(e) "Employees" as used in section six (6) hereof, and "employment" as used in section seven (7) hereof, shall include and pertain to members of the religious order operating the hospital even though the relationship of employer and employee does not exist between such members and the hospital.

Sec. 3. The ownership and maintenance of the laboratory and X-ray facilities and the operation of same under this Act are proper functions of a hospital.

Sec. 4. Pathology and radiology services performed in hospitals are the product of the joint contribution of hospitals, doctors and technicians but these services constitute medical services which must be performed by or under the direction and supervision of a doctor, and no hospital shall have the right, directly or indirectly, to direct, control or interfere with the professional medical acts and duties of the doctor in charge of the pathology or radiology facilities or of the technicians under his supervision. Nothing herein contained shall affect the rights of third parties as a result of negligence in the operation or maintenance of the aforesaid pathology and radiology facilities.

Sec. 5. Each hospital shall arrange for such services and for the direction and supervision of its pathology or radiology department by entering into either an oral or written agreement with a doctor who is a member of or acceptable to the hospital medical staff. Such doctor may or may not be a specialist. The department may be supervised and directed by a qualified member of the staff and specific services may be referred to a specialist, or the specialist may also direct and supervise the department as may be desired. Any contract so entered into shall be in accordance with the provisions of this Act.

Sec. 6. Unless the department is leased or unless the hospital and doctor mutually agree otherwise, technicians and other personnel, not including doctors, shall be employees of the hospital, subject to the rules and regulations of the hospital applicable to employees generally, but under the direction and supervision of the doctor in charge of the department as set forth elsewhere in this Act.

Sec. 7. The doctor and hospital shall mutually agree upon the employment of any technicians necessary for the proper operation of said department and no technicians shall be dismissed from said employment without the mutual consent of the parties, provided, however, that in the event the hospital and doctor are unable mutually to agree upon the hiring or discharge or disciplining of any employee of said department, the matter shall be promptly submitted to the joint conference committee for final determination.

Sec. 8. The contract between the hospital and doctor in charge of the laboratory or X-ray facilities may contain any provision for compen-

(Continued on Page 958)

IF "ORIENTAL FLU" SPREADS ACROSS the UNITED STATES



■ If the Far East Flu spreads across the United States, it may lead to the worst epidemic since 1918. That is an opinion publicly expressed today by many leading physicians and health officers in this country.

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sation of each upon which they mutually agree, provided, however, that no contract shall be entered into which in any way creates the relationship of employer and employee between the hospital and the doctor, and a percentage arrangement is not and shall not be construed to be unprofessional conduct on the part of the doctor or in violation of the statutes of this state upon the part of the hospital.

Sec. 9. The hospital admission agreement signed by the patient or his legal representative shall contain the following statement:

"Pathology and radiology services are medical services performed or supervised by doctors, and the personnel and facilities are or may be furnished by the hospital for said services. Charges for such services are or may be collected, however, by the hospital on behalf of said doctors pursuant to an agreement between said doctors and the hospital, and from said charges I consent that an agreed sum will be retained by the hospital in accordance with an existing agreement between the doctor and the hospital."

Sec. 10. The hospital bill shall properly include the charges for pathology and radiology services as long as the name of the doctor is stated and it fairly appears that the charge is for medical services. The said hospital bill shall also contain a statement substantially in the following form:

"The pathology and radiology charges are for medical services rendered by or under the direction of the doctor listed above and are collected by the hospital on behalf of the doctor, from which charges an agreed sum will be retained by the hospital in accordance with an existing agreement to which retention you consented at the time of your admission to the hospital."

Sec. 11. All fees to be charged by the doctors for pathology and radiology services shall be mutually agreed upon by the hospital and the doctor. In the event dispute shall arise between the parties the matter shall be submitted to the joint conference committee for final determination.

Sec. 12. Fees for radiology and pathology services must be paid for as medical and not hospital services. In all cases where payment is to be made by a corporation organized pursuant to chapter five hundred fourteen (514) of the Code, payment for radiology and pathology services shall be made by a medical service corporation and not by a hospital service corporation.

Sec. 13. Nothing in this Act is intended or should affect in any way that obligation of public hospitals under chapter three hundred forty-seven (347) or chapter three hundred eighty (380) of the Code, as well as the state hospital at Iowa City, to provide medical treatment for indigent persons or tuberculous patients as provided in chapters two hundred fifty-four (254) and two hundred fifty-five (255) of the Code wherein medical treatment is provided by hospitals of that category to patients of certain entitlement, nor to the operation by the state of mental or other hospitals authorized by law. Nothing herein shall in any way affect or limit the practice of dentistry or the practice of oral surgery by a dentist.

Sec. 14. Nothing herein shall deprive any hospital of its tax exempt or non-profit status.

Sec. 15. This Act, being deemed of immediate importance, shall take effect and be in full force from and after its passage and publication in *The Red Oak Express*, a newspaper published at Red Oak, Iowa, and in the *Winthrop News*, a newspaper published at Winthrop, Iowa.

CORRECTION

In the minutes of the Proceedings of the House of Delegates at the 1957 Annual Meeting an error appeared on page 825 of the July issue of *The Journal*. Inadvertently *The Journal* failed to state that Dr. Martin, the President, appointed Dr. A. C. Ormond, Zanesville, as a member of the Judicial and Professional Relations Committee, succeeding Dr. Charles W. Pavey, Columbus, and that this appointment together with other committee appointments was confirmed by the House of Delegates.

Cleveland Ophthalmological Club

At the recent meeting of the Cleveland Ophthalmological Club, Dr. Thayer L. Parry, Akron, was installed as president and the following officers elected: Dr. S. T. Forsythe, Shaker Heights, president-elect; Dr. William H. Evans, Youngstown, vice-president; Dr. Herman C. Weinberg, Cleveland Heights, secretary-treasurer; and Dr. Robert C. Kirk, Rocky River, assistant secretary-treasurer.

Lectureship Sponsored at OSU

A George Morris Curtis leadership has been established at Ohio State University Health Center in honor of the emeritus professor and former chairman of the Department of Research Surgery. Members of the Division of Thoracic Surgery have made available a nucleus of $2,500 which has been deposited in the Development Fund at the University. Sponsors expressed the hope that the amount might be increased to $10,000 which would provide an annual income of $600 and make possible lectures by leading surgeons of the world. Sponsors may be contacted through Dr. Karl P. Klassen, chief of the Division of Thoracic Surgery.

A one-week course, "Medical Aspects of Workmen's Compensation," will be presented by New York University Post-Graduate Medical School, 550 First Ave., New York 16, October 21-25. Details may be obtained from the school.



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Nation's Health Dollars . . .

Where They Come from, Where They Go; Figures for Private Services Compared with Those for Government Spending in Health and Welfare

HEALTH—personal and public—is big business. That is reflected in a report prepared by the Washington Office of the AMA, showing that in 1955 private health spending, including everything from patent medicines to surgeons' fees, was $11.2 billion, while public care (federal, state and local) was $3.9 billion. The following is a resume of the nation's public and private health and welfare picture, based on the statistics assembled by the AMA Washington office.

COST OF MEDICAL CARE IN U. S.

When the various parts that go into the Nation's health bill each year are added up, the total is staggering. Estimates of private and public spending include the cost of everything from patent medicine and toothpaste to surgeons' fees. Private care for the country in 1955 was placed at $11.2 billion, while public care (federal, state and local) was estimated at $3.9 billion. The following figures for private care costs are for 1955.

- $3.4 billion for physicians' charges.
- $3.7 billion for hospital charges.
- $2.3 billion for charges for drugs and appliances.
- $1.8 billion for other charges, including nursing, etc.

HEALTH AND MEDICAL RESOURCES

The medical "plant" that provides the country with the finest care of any nation is equally impressive when viewed statistically. In one area, that of medical school graduates, bare statistics fail to tell the whole story. They do not, for instance, reflect the increased utilization of physicians' skills and the advance of medical knowledge in treatment of patients.

- 225,579 physicians in U. S. in January, 1956.
- 1,604,000 hospital beds in U. S. in 1955.
- 430,000 professional nurses in 1955.
- 300,000 practical nurses, attendants, nurses' aides in 1955.
- 4,735 medical school graduates in 1930.
- 5,275 medical school graduates in 1940.
- 6,135 medical school graduates in 1950.
- 6,845 medical school graduates in 1956.

VOLUNTARY HEALTH INSURANCE

Another development of great importance in the furnishing of medical care has been the growth of voluntary health insurance. Twenty years ago the number of persons covered by some form of health insurance was only 1.5 million. When the drive was on for compulsory health insurance in 1949, just over 50 million persons were covered by voluntary insurance. Organized medicine contended then that voluntary coverage would expand, thus obviating the need for government insurance. The figures below prove this was a good estimate of the situation.

- 110,000,000 persons now covered for hospital charges.
- 92,000,000 persons now covered for physicians' charges for surgery.
- 55,000,000 persons now covered for physicians' medical charges in hospitals.
- 10,000,000 persons now covered for physicians' home and office call charges.
- 10,000,000 persons now covered for major medical expenses (catastrophic) compared with 1,200,000 covered in 1953.

HEALTH BILLS INTRODUCED IN CONGRESS

National legislators have not held back on the sponsoring of many health and medical bills. They cover just about every phase of medicine and human welfare. Most of them, of course, never get past committees. But as an indicator of the growing interest in health legislation these figures on bills introduced are illuminating:

- 250 measures, 1951-1952, 82nd Congress
- 407 measures, 1953-1954, 83rd Congress
- 571 measures, 1955-1956, 84th Congress

POTENTIAL BENEFICIARIES

Some of the greatest activity in the health field has involved laws and amendments to laws that widen the scope of medical care for federal beneficiaries. The very latest is Medicare voted last year for military dependents. Today nearly one out of every four persons, including over 22 million veterans, is eligible to receive at no cost to them some degree of medical care from the Federal Government.

- 22,599,000 living veterans as of January 1, 1957.
- 5,200,000 military personnel and their dependents.
- 300,000 beneficiaries of the Public Health Service, including 200,000 seamen, but excluding beneficiaries of Federal Employees' Compensation Act and Indians.
- 5,100,000 public assistance recipients.
- 370,000 Indians and Alaskan natives receiving care in 56 federal hospitals or in private facilities under contract.
- 4,000,000 beneficiaries of the Federal Bu-

(Continued on Page 962)

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- 48,627 PHS hospital admissions in 16 hospitals in 1956.
- 1,042,000 out-patient visits in 121 PHS out-patient facilities during 1956.
  Foreign Economic Aid Programs (entirely U. S.) and the World Health Organization (U. S. largest contributor) give limited health care in 92 foreign countries. Example: 25,300,000 children were vaccinated in 1956.
- 7,000,000 federal employees and their dependents (will be eligible for health care if proposed legislation is enacted).

FEDERAL HEALTH SPENDING

Under the impetus of new legislation enacted during the last few years—and particularly the new emphasis on medical research—the federal health budget is rising steadily. Bills introduced in the present (85th) Congress seek to expand many existing programs or set up new ones. The following table gives the total federal health bill for the current and last fiscal year and a breakdown of health-spending for the top three departments of government:

	Fiscal 1957	Fiscal 1956	Increase
• Total, all agencies.	$2,558,719,168	$2,268,826,576	12.8%
• Veterans' Administration.	$ 825,024,300	$ 790,185,800	4.4%
• Department of Defense.	$ 790,105,000	$ 818,104,500	(—3.8%)
• Department of HEW.	$ 772,661,800	$ 526,935,400	46.6%

SOCIAL SECURITY

Of all the programs of government enacted in the last several decades, none has had greater impact on the population or has been subject to more liberalizing amendments than the Social Security Act of 1935. It began on a relatively modest scale, with retirement payments of up to $10 a month for wage-earners who reached age 65. At that time, there were no benefits for the surviving spouse and children.

Now, 22 years later, the law has been amended to include: (1) survivorship benefits, (2) maximum monthly family survivorship payments as high as $200, and (3) a program enacted in 1956 and effective this July 1 for payment of social

(Continued on Page 964)



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A two months combined surgical course comprising general surgery, traumatic surgery, abdominal surgery, gastroenterology, proctology, gynecological surgery, urological surgery. Attendance at lectures, witnessing operations, examination of patients pre-operatively and post-operatively and follow-up in the wards post-operatively. Pathology, radiology, physical medicine, anesthesia. Cadaver demonstrations in surgical anatomy, thoracic surgery, proctology, orthopedics. Operative surgery and operative gynecology on the cadaver; attendance at departmental and general conferences.

EYE, EAR, NOSE, AND THROAT

A three months combined full time refresher course consisting of attendance at clinics, witnessing operations, lectures, demonstration of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; clinical and cadaver demonstrations in bronchoscopy, laryngeal surgery and surgery for facial palsy; refraction; radiology; pathology, bacteriology and embryology; physiology; neuro-anatomy; anesthesiology; physical medicine; allergy, as applied to clinical practice. Examination of patients preoperatively and follow-up post operatively in the wards and clinics. Attendance at departmental and general conferences.

RADIOLOGY

A comprehensive review of the physics and higher mathematics involved, film interpretation, all standard general roentgen diagnostic procedures, methods of application and doses of radiation therapy, both X-ray and radium, standard and special fluoroscopic procedures. A review of dermatological lesions and tumors susceptible to roentgen therapy is given, together with methods and dosage calculation of treatments. Special attention is given to the newer diagnostic methods associated with the employment of contrast media such as bronchography with Lipiodol, uterosalpingography, visualization of cardiac chambers, pre-renal insufflation and myelography. Discussions covering roentgen departmental management are also included; attendance at departmental and general conferences.

SURGICAL PATHOLOGY

A systemic series of lectures is presented covering the lesions encountered in the practice of surgery. These are illustrated with fresh material from the operating room, gross specimens from the museum and kodachrome and microprojected slides. The latest advances in blood grouping and transfusion reactions; didactic procedures, such as frozen sections, surgical biopsies, sponge biopsies, and aspiration of body fluid and secretions, are outlined.

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security benefits to disabled workers at age 50. Efforts continue to be made to amend the law, including a program of free hospitalization of the aged, disability benefits at all ages, and compulsory national health insurance. Statistics on the program as it exists today:

- 9,250,000 persons received OASI monthly checks in January, 1957.
- 70,000,000 wage-earners are covered and being taxed; 9 out of 10 persons in the U. S. are primarily "insured" or are their beneficiaries.
- $22,519,000,000 in U. S. Bonds in OASI Trust Fund.
- Payments from the OASI Trust Fund and contributions to it are now about equal.
- Tax rate is 2-1/4 per cent for employees and employers (4-1/2 per cent total); 3-3/8 per cent for self-employed.
- Under present law, 1975 rate will be 4-1/4 per cent for employees and employers (8-1/2 per cent total); 6-3/8 per cent for self-employed.
- Under a 1956 law, permanently and totally disabled persons aged 50-65 can get payments equal to retirement payments.
- Over 1,000,000 inquiries already have been made for disability payments or "disability freeze"; about one-half of the more than half a million formal applications have been approved.

* * *

- Labor organizations propose a $6,000 tax base on which contributions would be computed, instead of the present $4,200 base.

PUBLIC ASSISTANCE

A part of the Social Security Act, but a separate administrative operation, the public assistance program also was enacted in 1935. Its basic purpose was to assist states in providing subsistence for destitute families. From the beginning, the states have contributed a portion of funds for the various categories of recipients. Federal appropriations 20 years ago were about $209 million annually. Now they have increased more than seven-fold, so that the appropriation for the current fiscal year approximates $1.5 billion. There are four programs: aged, blind, permanently and totally disabled, dependent children.

Until amendments last year, unspecified federal-state funds were paid out for medical services of the needy. An educated guess has been that between $90 and $100 million of federal money has been going into such medical payments. A more accurate estimate should be forthcoming as a result of the 1956 amendments. These amendments set up a new category of federal-state payments for medical care over and above the old subsistence payment limits, with medical payments going directly to the physician, hospital, druggist, clinic or nursing home.

- 5,100,000 persons get monthly public assistance checks—medical costs included.
- Under new law, direct medical payments are to be made in behalf of assistance recipients to physicians, nursing homes, hospitals, and for drugs. These direct payments will probably exceed $200,000,000 and could reach $300,000,000 by 1958.

VETERANS

Another vast program with high demands on the federal budget is that for veterans medical care. The policy of the Federal Government is that wartime veterans with service-incurred disabilities are entitled to the best medical and hospital care that can be provided. The American Medical Association supports this policy. Congress in June, 1924, authorized VA to admit indigent non-service-connected veterans when there were spare beds. By 1957 roughly 75 per cent of all cases treated in VA hospitals were for injuries and diseases not originating during or aggravated by military service.

Now the problem is becoming more complicated as the veteran population grows older (World War I veteran in VA hospitals averages age 62) and becomes subject to chronic illnesses. Demands increase for use of VA facilities. Today VA requires: a full-time staff of over 4,600 physicians; 2,247 residents; 11,000 part-time consultants; and thousands of doctors on a contract basis for the agency's home-town care program.

22,599,000 total number of living veterans as of January, 1957.

- 121,865 total number of VA hospital beds as of January, 1957.
- 111,540 number of patients in VA hospital facilities on an average 1957 day.
- $619,614,000 will be spent by VA for in-patient care in fiscal year 1957.
- $ 82,638,000 will be spent for out-patient care in fiscal year 1957.
- More than 2 out of 3 veterans treated in VA hospitals are treated for non-service-connected conditions.

Gastroenterology

The World Congress of Gastroenterology and the 59th Annual Meeting of the American Gastroenterological Association will be held in Washington, D. C., at the Sheraton Park Hotel, May 25-31, 1958. Details may be secured from Dr. H. M. Pollard, secretary-general, University Hospital, Ann Arbor, Mich.

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

American Medical Association's support of the principle of the Bricker Amendment has been reiterated to a Senate Judiciary subcommittee by AMA Secretary Lull, stating that AMA "vigorously endorses the principle of a Constitutional amendment designed to restore to the states and to the Congress those legislative powers which until recent years had been thought to be secured to them by the Constitution," and "we are concerned that treaties or executive agreements may, in the future, even more seriously transfer the state regulation of medical practice into the hands of those who are unaware of the requirements or desires of the people of the several states."

* * *

Public Health Service and Defense Department are taking separate steps to cope with Far East influenza, both abroad and in U. S. PHS and AMA are drawing up plan of action in event of epidemic. Defense has announced policy of inoculating all overseas personnel and dependents. PHS is testing monovalent vaccine to combat the type A virus.

* * *

Small Business Administration is making loans to physicians and members of the other professions. Doctors needing funds may apply for loan to build or remodel offices, purchase equipment or for any other constructive purpose. Applicants need only be in private practice, solo or group. For information, write SBA, Washington, D. C.

* * *

Social Security Administration report says that during 1955, $4.14 out of every $100 in disposable income went for medical care, while 1948 figure was $3.89.

* * *

All Federal laws pertaining to medical care, hospitalization, pensions and other benefits for veterans have been packaged by a consolidation statute. The result is a compact 115-page booklet containing existing laws on compensable diseases, presumption of service-connection, VA medical organization and salaries, etc. May be had from House Committee on Veterans Affairs, Washington 25, D. C.

* * *

Public Health Service has released a report showing two thirds of all patients in proprietary nursing homes are women, average patient age is 80, one-fifth are confined to bed all the time, less than half are independently ambulatory, more than half are mentally confused at least part of the time, 40 per cent have cardiovascular conditions and many have arthritis or rheumatism.

Eight nations have jointly recommended that the World Health Organization undertake a major research program in epidemiology of cancer, "in the hope that a comparative study of the variations between cancer types in various countries would yield a clue to the origin of the disease which continues to baffle the research efforts of medical science." Sponsors are U. S., Britain, Australia, Russia, France, Iran, The Netherlands and Poland.

* * *

The National Library of Medicine no longer is lending books and other material over the counter to individuals; requests must be channeled through other libraries.

* * *

Public Health Service has opened investigation of what it means for a rural area to have no organized public health services. First place of call is Kit Carson County, Colorado, population 9,000. Data will be sought for appraisal of rural health requirements and ways of meeting them.

* * *

Postoffice Department reports quackery by mail at highest level in history and traffic increased immeasurably by mail order peddling of pills advertised as "no prescription necessary" tranquilizing drugs. In past 12 months, 46 fraud orders have been issued and 106 firms and individuals have signed good conduct agreements.

* * *

Federal Trade Commission ordered 18 manufacturers of antibiotics to answer a questionnaire and give detailed information on sales volume, costs, classification of employes, pricing policies and profits. Move stimulated by a few members of Congress who expressed view that "miracle drug" producers were making unreasonable profits.

Radiation for Industrial Physicians And Lawyers Is Subject of Course

A one week course in Radiation for Industrial Physicians and Lawyers will be offered by the Institute of Industrial Health and the College of Law of the University of Cincinnati during the week of September 9. Classes will be held at the Colleges of Medicine and Law of the University. Enrollment will be limited. Tuition is $100 per person. For further information and application, write to the Secretary, Institute of Industrial Health, Kettering Laboratory, College of Medicine, University of Cincinnati, Cincinnati 19, Ohio.

In Memoriam . . .

Ernest N. Beatty, M. D., formerly of Cincinnati; University of Cincinnati College of Medicine, 1920; aged 61; died June 8; member of the Ohio State Medical Association and the American Medical Association; past-president of the Cincinnati Obstetrical Society. Dr. Beatty was retired after practicing for 30 years in Cincinnati and was making his home in Erlanger, Ky. Survivors include his widow, a son and two daughters.

Hugo A. Berzins, M. D., Columbus; medical degree from the University of Latvia, Riga, 1930; aged 60; died June 5; member of the Ohio State Medical Association and the American Medical Association. A native and former resident of Latvia, Dr. Berzines had been practicing in Columbus for about five years. He died suddenly after returning from Nashville, Tenn., where he attended the graduation of his son from Vanderbilt University School of Medicine. Other survivors include his widow, a daughter and his mother.

Ernest H. Cox, M. D., Chagrin Falls; Western Reserve University School of Medicine, 1905; aged 78; died June 9; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; member of the Cleveland Clinical Club and the Cleveland Surgical Society. A practicing physician in the Cleveland area for more than a half century, Dr. Cox had been honored with the 50-Year Award of the OSMA. He was a member of several Masonic bodies. Survivors include his widow, three sons and a brother.

Roscoe Scott Hallock, M. D., Cleveland; University of Wooster, Medical Department, Cleveland, 1909; aged 76; died June 23; member of the Ohio State Medical Association; Fellow of the American College of Surgeons. Dr. Hallock had been a practicing physician over a period of 48 years. He moved to Cleveland in 1928, having started practice in North Jackson. Dr. Hallock was a member of the Church of Christ. Surviving are his widow, a son, a daughter, a brother and a sister.

Merle D. McCutcheon, M. D., East Liverpool; College of Physicians and Surgeons, Baltimore, 1908; aged 72; died June 26; member of the Ohio State Medical Association, the American Medical Association and the Radiological Society of North America. Dr. McCutcheon served virtually all of his professional career in East Liverpool, having taken time out for postgraduate study in Scotland and at Harvard and for service in the Medical Corps during World War I. He was a member of several Masonic bodies, the Chamber of Commerce and the Presbyterian Church. Survivors include his widow, two sons, two brothers and a sister.

Joseph B. Chronik, M. D., Dunedin, Florida; Temple University School of Medicine, 1921; aged 63; died June 19 in a traffic accident; former member of the Ohio State Medical Association and the American Medical Association. Dr. Chronik had been a practicing physician in Columbus for 35 years before retiring about a year ago. He was a veteran of World War I and was a member of the Harbor Hills Polo Club at Buckeye Lake. Mrs. Chronik died with her husband in the accident while the couple was on the way to Buckeye Lake where their surviving daughter resides.

John Francis Corrigan, M. D., Cleveland; Western Reserve University School of Medicine, 1913; aged 69; died June 24; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. A life resident of Cleveland, Dr. Corrigan practiced there for 43 years. Survivors include his widow, four sons and a daughter.

Albert G. Hartenstein, M. D., Belpre; University of Maryland School of Medicine, 1919; aged 82; died June 24. Dr. Hartenstein practiced for the past 25 years in Belpre and Parkersburg and earlier in Nebraska and Maryland. He was a member of the Masonic Lodge and the Lutheran Church. Survivors include his widow and several brothers and sisters.

William J. Gallagher, M. D., St. Louis, Mo.; St. Louis Univ. School of Medicine, 1920; aged 63; died June 19; member of the Missouri State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Surgery. A practicing physician in St. Louis for all of his career, Dr. Gallagher was well known in Cleveland, his former home. Dr. Farrell T. Gallagher and Msgr. Daniel T. Gallagher of Lakewood are brothers of the deceased. Other survivors include his widow; two daughters; a son, Dr. William J. Gallagher, Jr., of the U. S. Navy; his mother, and four sisters.

John Jay Harrington, M. D., Clearwater, Florida; University School of Medicine, Philadelphia, 1903; aged 78; died June 21 in Westerville while on a visit there. A member of the American Psychiatric Association, Dr. Harrington was formerly on the staff of Columbus State Hospital. He retired in 1944. His widow and a daughter survive.

George C. Malley, M. D., Zanesville; State University of New York College of Medicine, 1930; aged 53; died June 12; member of the Ohio State Medical Association and the American Medical Association through 1956; member of the American Academy of Pediatrics; diplomate of the American Board of Pediatrics. Dr. Malley

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had been a practicing physician in Zanesville since 1933. He was active in a number of community projects including Boy Scout work, and was a member of the Catholic Church. Surviving are his widow, two sons, a daughter, two brothers and a sister.

Robert B. Pratt, M. D., Bellefontaine; Jefferson Medical College of Philadelphia, 1910; aged 70; died June 4; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Surgery. Dr. Pratt was a native of Bellefontaine and served all of professional career in that community, following in the footsteps of his father and grandfather who practiced in the area. During World War I he served with the Army Medical Corps and received the Croix de Guerre from France. For many years he was surgeon for the New York Central System in the area and was active in such organizations as the local Red Cross and Cancer Society. Survivors include his widow, a daughter, a sister and a brother, Dr. Lester L. Pratt, of San Diego, Calif.

Anthony J. Rejent, M. D., Toledo; St. Louis University School of Medicine, 1921; aged 60; died June 23; former member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Physicians. A native of Toledo, Dr. Rejent served all of his professional career there, and for several years was city physician. He was a member of the Catholic Church, the Holy Name Society, the Heather Down Country Club, the Civic Club and the American Legion. Surviving are his widow, two sons, a sister and two brothers.

E. Florence Smith, M. D., Columbus; Laura Memorial Women's Medical College, Cincinnati, 1901 and Eclectic Medical College, Cincinnati, 1904; aged 86; died June 27. Dr. Smith practiced in Newark before she retired about 15 years ago. Two brothers survive.

Bernard Louis Spitzig, M. D., Lakewood; St. Louis University School of Medicine, 1910; aged 70; died June 13; former member of the Ohio State Medical Association. Dr. Spitzig had been a practicing physician in the Cleveland area since 1913. He was a member of the Catholic Church. A sister survives.

Julius C. Speck, M. D., Youngstown; Jefferson Medical College of Philadelphia, 1919; aged 61; died June 1; former member of the Ohio State Medical Association. Dr. Speck moved to Youngstown 38 years ago. He had been in retirement for a number of years. A veteran of World War I, he is survived by his mother, a sister, and two brothers, Dr. M. Henry Speck of Youngstown, and Dr. Myron Speck of Cleveland.

Melville F. Walker, M. D., Dillsboro, Ind.; Eclectic Medical College, Cincinnati, 1917; aged 62; died April 3; member of the Ohio State Medical Association and the American Medical Association. Dr. Walker served in the Army Medical Corps during World War I, and after the war returned to Cincinnati where he practiced for 36 years. He retired in 1955 because of ill health. He was surgeon for the New York Central Railway for many years. Surviving are his widow, a daughter and a son.

Report New High on Number of Ohioans Protected by Health Insurance

The number of people in Ohio who are protected by voluntary health insurance reached a new high by July 1, the Health Insurance Council reported. As of this date the Council estimates that over 8,400,000 persons were protected by some form of insurance designed to help pay hospital and doctor bills.

This figure, the Council said, is part of the continued growth of health insurance throughout the country, which was revealed last May in its 11th annual survey of the extent of voluntary health insurance coverage for 1956. The number of people covered by some form of health insurance in the nation today is more than 118 million, or over 70 percent of the U. S. civilian population.

In releasing the findings of its survey, which is based on reports of insurance programs of insurance companies, Blue Cross-Blue Shield and other health care plans, the Council went on to say that there were 8,221,000 persons covered by hospital expense insurance in Ohio as of December 31, 1956. The total for 1955 of the number of persons covered for expenses incurred while in the hospital was 7,743,000.

Surgical expense insurance, which helps to defray the cost of physicians' charges for operations rose to 6,484,000, as compared with 5,998,000 the year before.

Persons protected by regular medical expense insurance, providing for doctor visits for nonsurgical care, numbered 3,020,000 in 1956, as against the previous year's figure of 2,392,000.

The Health Insurance Council, which is a federation of eight insurance associations representing over 90 per cent of the accident and health insurance business handled by insurance companies, stated that this growth reflects the desire of the people of Ohio to help protect themselves against the cost of accident and illness.

Dr. Verne K. Harvey, who set up the Civil Service Commission's medical division and has served as its medical director for 17 years, left the agency June 28 to become professional services director at the two Indianapolis VA hospitals.

Dr. H. M. Platter was the subject of a feature article in the *Columbus Citizen* on June 26. In August Dr. Platter will complete his 40th year as secretary of the State Medical Board. He has been in the profession for 64 years.

Entertainment Expense Deductions . . .

Such Expenses Can Be Deducted in Federal Income Tax Returns If They Meet Certain Requisites; Warning and Advice Are Offered

ONE of the Washington tax letters which is quite popular among business and professional men recently published this warning: "Watch your expense accounts. The gov't will be a lot tougher about what it allows you to deduct in the future than it has been in past. Orders have just gone out from headquarters of Revenue Service telling all field offices to 'scrutinize expense accounts closely.'"

Physicians ordinarily do not run into trouble with the tax officials in making deductions for many categories of business expenses. However, there are some classifications which present a real problem, such as claims for deductions for entertainment, club dues, travel, and maintenance of autos.

CLUB DUES; TRAVEL

On the matter of social club dues, it has been suggested by tax authorities that they be pro rated, deducting part of them as business expense and regarding the balance as personal nondeductible items.

The question as to how much can be deducted for travel to and from professional meetings is pretty well understood as is the deductions allowed for automobile used for professional business.

The matter of deductions for "entertainment" is causing some physicians in Ohio headaches and controversy with the tax authorities. So the balance of this article will cover the question of entertainment deductions.

WHAT THE JOURNAL SAID

In the regular annual Federal Income Tax Roundup story published in December, 1956, issue of *The Journal*, the following statement appeared:

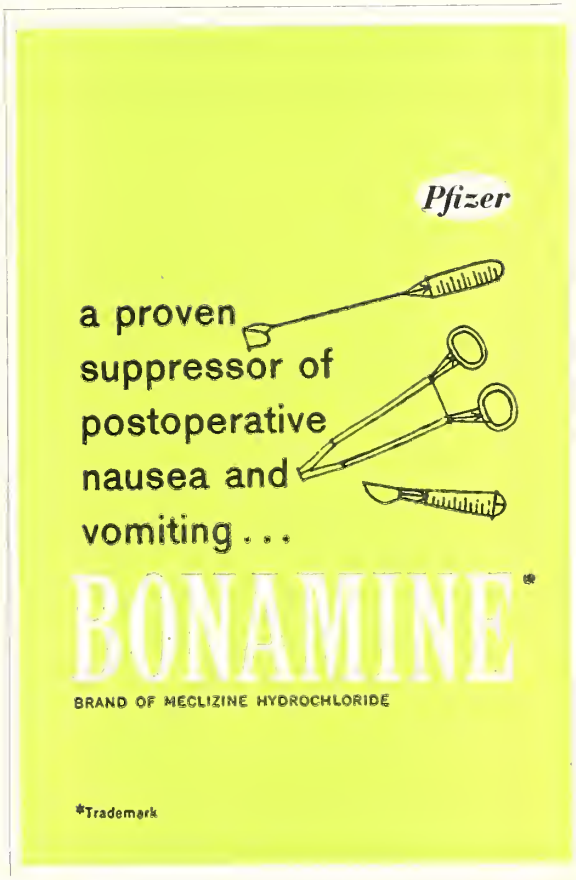
"**Entertainment.**—Entertainment expenses incurred as a means of enhancing a physician's practice, such as the entertainment of physicians who refer patients, and similar expenditures to attract and retain patients, are proper business expenses. The physician must be prepared to prove that such expenditures have a direct income-producing relationship to his practice; otherwise, they will be disallowed. A detailed record should be kept of each item of business entertainment expense, together with dates, amounts, names of persons entertained, the nature of the expense, and recipients of payment. Wherever possible, such expenses should be made on a charge account and paid by check so that a permanent record may be retained. The physician must be able to show from his other records the business benefit he derives from the persons he entertains. Extensive business entertainment or the expenditure of an unusually large proportion of income for this purpose makes it difficult to establish that the entire amount of these expenditures has a direct income-producing relationship to the physician's practice."

MATTER OF ETHICS

Two years ago (August, 1955) *The Journal* published this information on entertainment expenses:

"Understand some physicians have had their professional entertainment expenses appearing on their income tax return challenged as 'unethical' by internal revenue agents. They, as well as other physicians, will be interested in certain correspondence between Dr. George F. Lull of the AMA and the Internal Revenue Bureau on this subject.

The attitude of the AMA and the policy of the bureau are summarized in the following excerpts of a letter from the bureau to Dr. Lull in



which the position of the AMA is not challenged but which does emphasize that the decision in each case depends on the facts in such case:

LETTER FROM BUREAU

"'This is in further response to your letter of February 21, 1955, addressed to Commissioner Andrews, relative to the position being taken by internal revenue agents that business entertainment expenses claimed by physicians on their Federal Income tax returns are "unethical" and, consequently, not allowable. You have been informed that in some instances our agents have asserted that the American Medical Association itself considers such expenses as unethical.

"'You state that your association does not consider legitimate entertainment expenses incurred by physicians in the pursuit of their profession as either unethical or contrary to public policy, and you believe that in the examination of income tax returns physicians should be accorded the same treatment as that accorded other professional men, or business men in general.

"'Under the circumstances you request that those internal revenue agents responsible for the examination of income tax returns be advised accordingly.

"'The administration of the provisions of Section 23a(a)(1)(A) of the Internal Revenue Code for 1939 (Section 162 of the Internal Revenue Code for 1954), which allows 'ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business,' involves a factual determination. Accordingly, the allowance of such expenses must be based upon the facts in each case. Since you did not call to our attention any specific cases, we are not in a position to determine whether entertainment expenses have in any instance been improperly recommended for disallowance.

"'In order, however, to insure uniform application of this provision of the law, the circumstances which you have recited will be brought to the attention of our field people.'"

ARTICLE IN GP

An excellent article on this subject was published in the April, 1956, issue of *GP*. It was written by MacF. Cahal, an attorney and executive secretary of the American Academy of General Practice. Part of the article is quoted below:

"Can physicians deduct costs incurred for entertainment of medical colleagues and patients in figuring their net taxable income? Yes. *But*, in the event such deductions are challenged, they can be sustained only by proof consisting of satisfactory evidence. This means evidence satisfactory to the Bureau of Internal Revenue! The burden of proof is on the taxpayer.

"Are general practitioners subject to a different rule than are specialists regarding such expenses? No. Contrary to the belief expressed by a number of Academy members, general practitioners are in exactly the same position as specialists. This assumes, of course, that the facts and the evidence are equal.

"In an article appearing in a recent issue of a medical journal, the author states that, 'New regulations have been issued from Washington which indicate that entertainment expense (for

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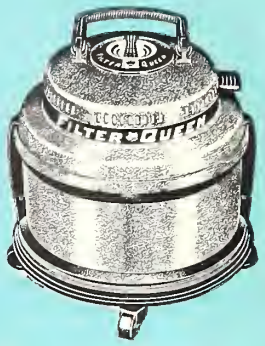
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doctors) is to be ruled out entirely.' This is untrue. No new law on this subject has been passed, and no new regulations issued. The Internal Revenue Code of 1954 re-enacts without change in Section 162 the provisions of Section 23 (a) of the earlier 1939 Code.

"At the opposite extreme is a statement appearing in another journal. The author states that, 'When you join a club to cement your relations with people you believe will help you professionally, you can deduct your dues.' This categorical statement is too simple to be wholly true.

DECISIONS REFERRED TO

"Self-employed professional persons are subject to the same rules of law in establishing their right to deduct entertainment expenses. Typical of the controversies on this issue reaching the U. S. Tax Court is one involving country club expenses claimed by an attorney as a business expense and therefore deductible under Code Section 23 (a) (1) (A). The court held that amounts were not deductible, because proof offered by the taxpayer did not show that 'the purpose of the expenditure was primarily business rather than social or personal and that the business in which the taxpayer was engaged benefited thereby.'

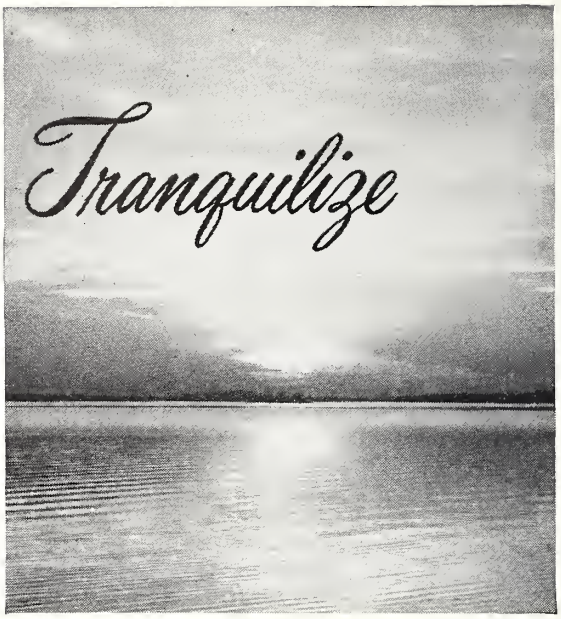
"On the other hand, there are numerous decisions, in which entertainment expenses by such professional people were allowed. Frequently, where the claimed deduction seems unreasonable, as in the case of total expenses at the club, the Bureau compromises by allowing a portion of the total as a business deduction. In a 1947 case, again involving an attorney, the Tax Court disallowed club dues at two different clubs as an expense, but did allow one-half the total house bills at both clubs because it found that the taxpayer actually used the clubs at least 50 per cent of the time for entertaining clients and other purposes 'incident to the practice of his profession.'

EACH CASE ON OWN MERITS

"Remember that each case is decided on its particular facts and merit. There is no categorical rule about what specific expenses may be deducted.

"The Internal Revenue Code of 1954 (Public Law 59) provides in Section 162 (a) that "all ordinary and necessary expenses incurred in carrying on any trade or business" may be deducted from gross income from a business or profession. To prove that entertainment expenses are directly related to professional activities and are both ordinary and reasonable is sometimes difficult for doctors.

"This is not to state physicians cannot deduct legitimate entertainment expenses. But, to sustain them, they must show they are directly related to their professional practice, that the expenses are made in anticipation of increasing their professional income, and that such expenses



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*REFERENCE: J.A.M.A. 163: 359, 1957 (February 2)

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are ordinary in the medical profession and necessary for maintenance of practice.

MUST HAVE PROOF

"Most physicians who have had claimed deductions disallowed failed to sustain them because they were unable to present adequate records to support the expenses. Even if a doctor can prove that expenses of this type are directly related to his professional practice and both ordinary and reasonable, he will not be able to deduct such items from gross business income unless he can present adequate records to substantiate them. It is a good rule, in the case of entertainment expenses, therefore, to keep all cancelled checks and club statements. A record should be made, either in the taxpayer's books or on the statements, showing who, where, when and how much.

"Where adequate records are not kept, the collector will estimate the portion properly allowable as a business expense.

MUST PROVE BENEFIT

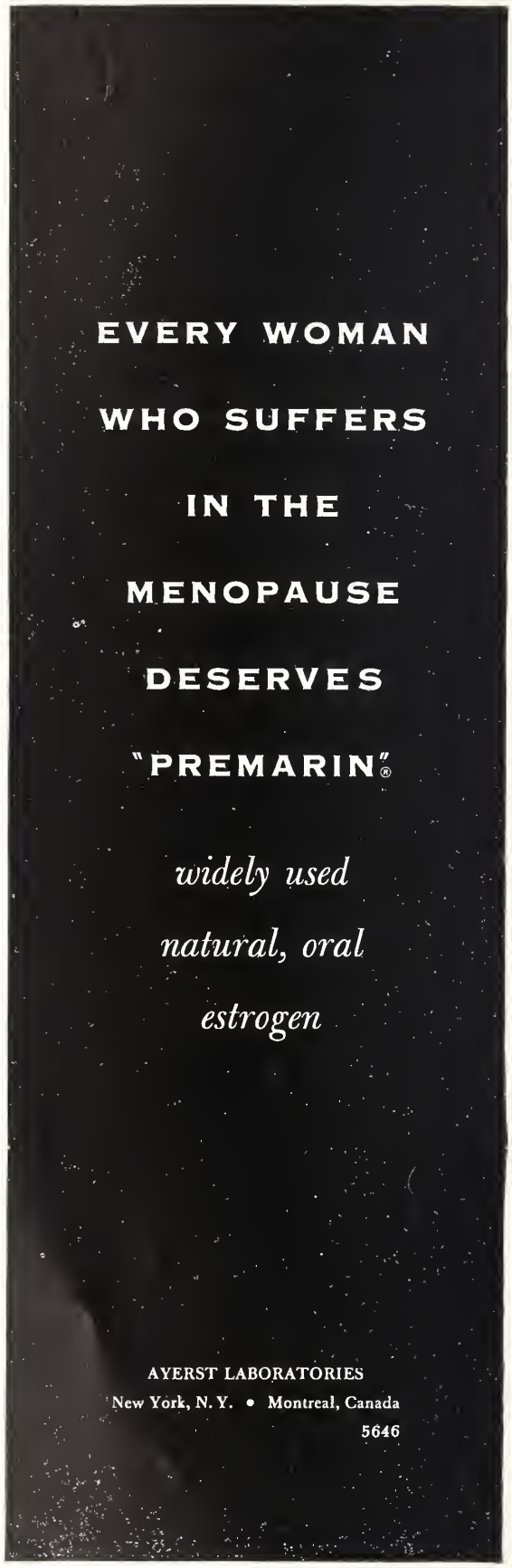
"On the basis of cases decided by the Tax Court, one final and important test must be met. The physician must be able to convince the collector that the expense was made in reasonable anticipation of professional benefit. He must present proof as to the original purpose in taking out a club membership and the extent to which the membership is used for business purposes.

"As stated above, all entertainment expenses, including expenditures for gifts in the form of flowers, liquor or other presents, may be deductible if they meet proper tests. In all such cases, the taxpayer must be able to furnish clear evidence that the expenditures were for professional purposes rather than for purely personal purposes. Moreover, the Internal Revenue Service has been taking the position that deductible entertainment expenses include only the portion of such expense which was applicable to the guest.

"Since it is so very difficult to draw the line between expenses which were for professional purposes and those which were for personal reasons, these deductions are subject to particularly close scrutiny.

"The best way to sustain a deduction for entertainment expenses is to be able to show that such expenditures actually resulted in benefit to your practice. If, for instance, a general practitioner can show that he entertained a specialist who subsequently referred to him a patient who needed the services of a family doctor, he has a practically iron-clad case. At the other extreme, is the case where a general practitioner has claimed deduction for expenses incurred in entertaining a person or a group of individuals who could not conceivably have rendered any service to him which might have increased his income.

"The most important rule of all to follow, is to keep accurate records with adequate explanations of every claimed deduction."



You and Your Public . . .

Individual Physician Establishes Own Public Relations with Patients Through Three Sources: Telephone, the Mail and Personal Contact

PUBLIC RELATIONS is created, for good or bad, through communications, and there are three means of communication through which the individual physician establishes his own PR "personality" with his patients.

The first thing to remember in evaluating PR personality is that not just the physician but his office, his office personnel and their actions all are considered by the patient, knowingly or unknowingly, when the patient paints a mental picture of his physician.

For this reason, the PR-wise doctor will set down a simple but effective set of rules for both himself and his staff to follow. These rules can be listed according to the method of contact with the patient.

Taking these "lines of communication" in reverse order of frequency, first consider the art of writing a letter. A cold, stiff, precise letter may very well convey clearly the intended message, but, if written with a little consideration can convey much more. Nobody likes to be thought of as merely an address.

Another line of communication is the telephone. Telephone courtesy is important enough that telephone companies have highly trained personnel to carry out one duty. That duty is to instruct persons in proper and considerate handling of telephone calls.

The doctor's receptionist who answers the telephone correctly and handles telephone conversations properly scores heavily with patients.

Incidentally, the doctor should let his office staff know where he is at all times. It seems to have a good psychological effect on the patient just to know where his doctor is. In addition, if the call is a real emergency, then the doctor's staff can reassure the patient that the doctor will be contacted immediately.

Next comes the most important means of PR communications—personal contact. Results of the 1956 AMA survey on what people think of the medical profession showed that most patients



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think highly of their personal physicians. This means that most physicians are doing well in the personal contact aspect of their public relations.

For the doctor who feels he may be a little below par in this item, there is a simple rule to follow—treat others as you would want to be treated.

To simplify a guide for good public relations—little things count a lot.

* * *

An excellent means of maintaining the PR factor with patients is that used by a New Jersey physician. Dr. May Bacon, Bridgeton, N. J., provides a reminder to patients that contains valuable information pertaining to apointments, office hours, telephone calls and emergencies.

The handy little pamphlet is small enough to fit into a billfold, yet covers the subject thoroughly and clearly. It reminds patients of Dr. Bacon's office hours, instructs them on how to telephone to obtain emergency treatment, points out the best hours for telephone calls involving routine matters, and outlines the procedure for obtaining evening and Sunday appointments.

The folder also emphasizes: "We are always, on any day at any hour, willing to see our patients when they are suddenly and seriously ill or injured."

It is prefaced with the statement that "the enclosed information, * * *, is valuable to you. It will help both YOU and your Doctor if you will read it carefully, and keep it available for easy reference."

In addition to providing copies for each patient, supplies are kept in several convenient spots in the waiting room, and often one is enclosed in professional correspondence." Dr. Bacon reports "it has been very helpful in our practice."

American College of Surgeons Meets In Atlantic City, Oct. 14-18

Progress in surgery as it is emerging from research laboratories and operating rooms is the theme of the 43rd annual Clinical Congress of the American College of Surgeons, meeting in Atlantic City, New Jersey, October 14 through 18.

More than 10,000 surgeons, physicians, students and related medical personnel from all parts of the nation and many foreign countries will attend this world's largest meeting of surgeons, with more than 1,000 taking part in the various programs as authors of research reports, lecturers, leaders of symposia, participants in panel discussions, and operating surgeons in motion pictures and closed-circuit television. For details write the college at 40 E. Erie St., Chicago 11, Ill.

Dr. Charles F. Shook, Toledo, has been named on the new Committee on Industrial Nursing which has been established by the American Medical Association's Council on Industrial Health.

Cook County
Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES—FALL, 1957

SURGERY—Surgical Technic, two weeks, Sept. 16, Oct. 28. Surgery of Colon & Rectum, one week, Sept. 16. Basic Principles in General Surgery, two weeks, Oct. 14. Surgical Anatomy & Clinical Surgery, two weeks, Sept. 30. Treatment of Varicose Veins, Sept. 9. Thoracic Surgery, one week, Oct. 7. Esophageal Surgery, one week, Sept. 30. Gallbladder Surgery, three days, Nov. 4. Surgery of Hernia, three days, Nov. 7. General Surgery, two weeks, Sept. 23; one week, Oct. 28. Fractures & Traumatic Surgery, two weeks, Oct. 21.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Sept. 16. Vaginal Approach to Pelvic Surgery, one week, Sept. 9. General & Surgical Obstetrics, two weeks, Sept. 30.

MEDICINE—General Review Course, two weeks, Sept. 23. Electrocardiography & Heart Disease, two weeks, Oct. 7. Hematology, one week, Sept. 9. Gastroscopy & Gastroenterology, two weeks, Sept. 9. Dermatology, two weeks, Oct. 14.

RADIOLOGY—Diagnostic X-Ray, two weeks, Sept. 16. Clinical Uses of Radioisotopes, two weeks, Oct. 7.

UROLOGY—Two-Week Intensive Course, Oct. 7.

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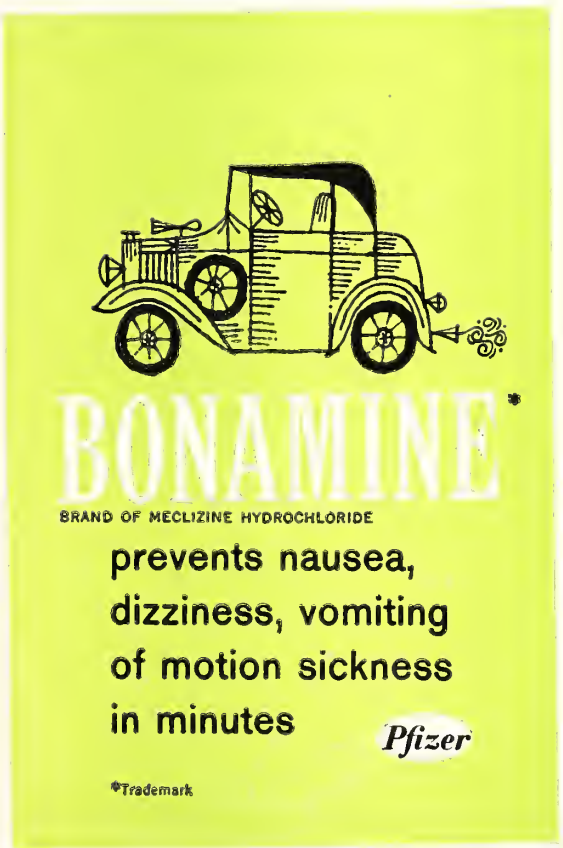
CUYAHOGA

At the annual meeting of the Academy of Medicine of Cleveland, the following eight new directors were announced as elected to serve on the 24-member board until May, 1960: Drs. Francis L. Browning, Webb P. Chamberlain, Jr., Eugene A. Ferreri, William E. Forsythe, Philip F. Partington, Philip J. Robechek, Paul J. Schildt and Howard P. Taylor.

The Board of Directors met and elected officers. Dr. Thomas D. Kinney assumed office as president to succeed Dr. A. Macon Leigh. The new president-elect is Dr. Chester R. Jabolonski; vice-president, Dr. D. Kirk Spitler, and secretary-treasurer, Dr. B. B. Sankey (re-elected).

An information center on poison has been organized to operate through the switchboard of the Academy of Medicine of Cleveland with the cooperation of University Hospitals. The center furnishes information on contents of products which might be swallowed by children. The Cleveland Foundation contributed an initial $7,150 for the center.

Another accomplishment to which the Academy is contributing is publication of a directory of services for the chronically ill. The directory is edited by Dr. John Martin and published in conjunction with the Cleveland Welfare Federation.



GREENE

The final meeting before summer vacation for the Greene County Medical Society was held on June 13 at the Greene County Memorial Hospital, Xenia. On the scientific program were Dr. Paul M. DeMerit, clinical assistant professor in the Department of Medicine, Ohio State University, and Dr. Robert N. Watman, assistant professor in the OSU Department of Surgery. Their subject was "Management of Interesting Medical and Surgical Problems in Geriatric Patients."

HAMILTON

Officers and delegates of the Academy of Medicine of Cincinnati were elected recently to take office in September. At the opening meeting in the fall Dr. George X. Schwemlein will assume office as president to succeed Dr. Howard D. Fabing. The following other persons were elected to take office at the same time: Dr. J. Robert Hudson, president-elect; Dr. Norbert H. Cavanaugh, secretary; Dr. Harvey G. McCandless, treasurer; Dr. Joseph N. Ganim, trustee; Dr. Morton Hamburger, councilman-at-large; Drs. Harry K. Hines, Stuart A. Schloss, James D. Phinney and Thomas A. Radley, delegates; Drs. Clayton R. Sikes, Jr., Robert W. Woliung and Robert M. Sherman, alternate delegates.

MUSKINGUM

Dr. Robert M. Zollinger, chairman of the Department of Surgery, Ohio State University, was guest speaker at the June 4 meeting of the Muskingum County Academy of Medicine, held at the Zanesville Country Club. His subject was "Diseases of the Pancreas."

SCIOTO

A panel discussion "GP — Specialist Interrelationship" was the program feature at the June 10 meeting of the Scioto County Medical Society. The meeting was held at the Nurses' Recreation Hall of General Hospital, Portsmouth, with a buffet supper.

At the July 18 meeting, the program centered around a discussion of problems concerning public aid programs.

SENECA

Thirteen members attended the bi-monthly dinner meeting of the Seneca County Medical Society on June 19 at the Mohawk Golf Club, Tiffin. Dr. Leonard Gaydos, president, conducted the business meeting, during which Dr. Thomas

Watkins was elected secretary-treasurer, succeeding Dr. R. K. Rawers.

SUMMIT

Speaker for the June 4 meeting of the Summit County Medical Society was Dr. Frederick Robbins, Cleveland, chief of pediatrics and contagious diseases at Cleveland City Hospital, and Nobel Prize winner in connection with polio vaccine research. His talk centered around the discriminate use of antibiotic drugs.

With guests present from Salem, Canton, East Liverpool, Minerva and Malvern, more than 50 persons attended the annual spring lecture meeting of the Alliance City Hospital's medical staff.

Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, was guest speaker. He spoke on the topic, "The Recognition and Present Day Treatment of Leukemic States and the Lymphomata." He was introduced by Dr. David Fitzelle. Following the lecture, 40 persons attended a dinner at the Elks Home.

COMING MEETINGS

American Medical Association, Clinical Meeting, Philadelphia, December 3-6.

AMA Public Relations Institute, Chicago, August 28-29.

American Medical Writers' Association, 14th Annual Meeting, Sheraton-Jefferson Hotel, St. Louis, September 27-28.

Indiana State Medical Association, Annual Meeting, French Lick, October 6-9.

Course in Pulmonary Diseases, Ohio State University, September 27-28.

Course in Radiation for Industrial Physicians and Lawyers, University of Cincinnati, Week of September 9.

Eighth Councilor District Meeting, Marietta, October 3.

Kentucky State Medical Association, Annual Meeting, Louisville, September 17-19.

Medical Society of the State of Pennsylvania, Annual Meeting, Pittsburgh, September 15-20.

Michigan State Medical Society, Annual Meeting, Grand Rapids, September 25-27.

National Medical Association, Hotel Hollenden, Cleveland, August 12-15.

Northwestern Ohio Medical Association, Annual Program, Defiance College, Defiance, October 23.

Occupational Skin Problems, Institute of Industrial Health, University of Cincinnati, October 28 - November 1.

Ohio Academy of General Practice, Seventh Annual Scientific Assembly, Columbus, September 18-19.

Ohio Chapter, American College of Surgeons, Second Annual Meeting, Toledo, September 6-7.

Sixth Councilor District Postgraduate Day, Canton, October 23.

INDEX TO ADVERTISERS

Abbott Laboratories 895, 956-957, 967
Ames Company, Inc. 870
Appalachian Hall 894
Armour Laboratories, The, ... 886-887
Ayerst Laboratories, Inc. 974
Barry Laboratories, Inc. 961
Burroughs, Wellcome & Co. (U. S. A.) Inc. 897
California State Personnel Board 979
Children's Convalescent Home and Rehabilitation Center 898
Ciba Pharmaceutical Products, Inc. 875
Coca-Cola Company 894
Columbus Pharmacal Company 962
Cook County Graduate School of Medicine 976
Davies, Rose & Co., Ltd. 970
Desitin Chemical Company 874
Flint, Eaton & Company 881
Geigy Pharmaceuticals, Inc. 890
Harding Sanitarium 888
Health-Mor, Inc. 971
Hoffmann-LaRoche, Inc. ..... Insert between pages 884 - 885
Lakeside Laboratories, Inc. 869
Lederle Laboratories 878-879, 930-931, 953
Lewal Pharmaceutical Company 896
Lilly, Eli, and Company 900
Mallard, Inc. 972
McMillen Sanitarium 888
Mead Johnson & Company, Pablum Products Division 876
Medical Protective Company 975
New York Polyclinic Medical Schools 963
Parke, Davis & Company ..... 980 and Inside Back Cover
Patch, E. L., Company, The 889
Pfizer, Chas. & Co., Inc. 877, 969, 977
Robins, A. H., Co., Inc. 893
Roerig, J. B., & Co. 891
Sanborn Company 892
Sawyer Sanatorium 885
Schering Corporation 899
Scroggins, Clayton L., Associates (Medical-Dental Management) 973
Searle, G. D., & Company 949
Smith, Kline & French Laboratories ..... 959, and Back Cover
Squibb, E. R., & Sons, Division of Olin-Mathieson Chemical Corporation 883
Stoneman Press 963
Tutag, S. J., & Company 973
Wallace Laboratories ..... Insert Between Pages 964 - 965
Wendt-Bristol Company 976
Windsor Hospital, Inc. 975
Winthrop Laboratories 951

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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Recent CD Publications

"LP Gas for Civil Defense" prepared by Liquefied Petroleum Gas Association. It may be obtained from Federal Civil Defense Administration, Battle Creek, Michigan.

"Attack Warning Channels and Procedures for Civilians," FCDA Advisory Bulletin No. 211, April 5, 1957, Federal Civil Defense Administration, Battle Creek, Michigan.

Society for Crippled Children To Meet in Chicago

The 1957 annual convention of the National Society for Crippled Children and Adults—the Easter Seal Society—will be held October 31 to November 2 in Chicago's Palmer House, Dean W. Roberts, M. D., executive director, announced.

Dr. James B. Johnson, Newark, Ohio, is chairman of the 1957 convention. Details may be obtained from local societies or by writing the national group at 11 S. LaSalle St., Chicago 3, Ill.

Dr. Albert B. Sabin, Cincinnati, presented a paper at the fourth International Poliomyelitis Congress in Geneva, Switzerland, July 9, on the subject, "Properties and Behavior of Orally Administered Attenuated Poliovirus Vaccine."

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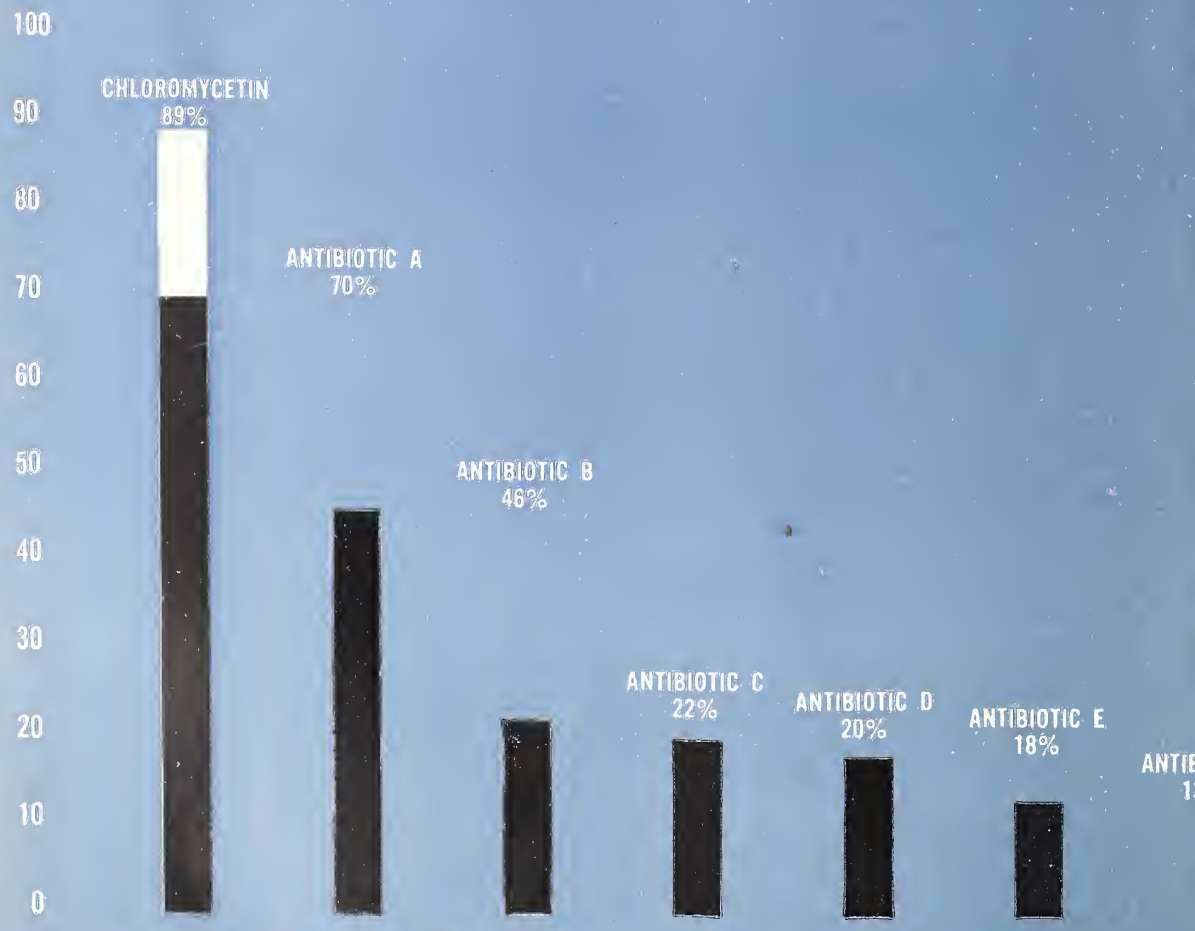
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BUTLER—Ralph H. Leyrer, President, Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton. Beginning in February 4th Wednesday of alternate months.

CLERMONT—Charles M. Simmons, President, Bethel; John T. Crone, Secretary, Milford. 3rd Wednesday, monthly.

CLINTON—John K. Williams, President, Wilmington; Edmond K. Yantes, Secretary, Wilmington. 1st Tuesday.

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GREENE—Joseph R. Schauer, President, Fairborn; Norman G. Linton, Secretary, Jamestown. 2nd Thursday, monthly.

MIAMI—Charles M. Oxley, President, Troy; Dale A. Hudson, Secretary, Piqua. 1st Friday, monthly, except July, August.

MONTGOMERY—R. Dean Dooley, President, Dayton; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Building, Dayton. 1st Friday, monthly, except July, August and September.

PREBLE—E. P. Trittschuh, President, Lewisburg; John R. Bowman, Secretary, Eaton. November of each year.

SHELBY—James W. Tirey, President, Anna; Robert H. Lanfersieck, Secretary, Sidney. 1st Tuesday, monthly.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Angiocardiographic Interpretation in Congenital Heart Disease, by Herbert L. Abrams, M. D., and Henry C. Kaplan, M. D. ($11.75. *C. C. Thomas Co., Springfield, Ill.)* Part I describes the historical background of angiocardiographic techniques, contrasting media and roentgen equipment, reactions, general principles of interpretation and the role of aortography in diagnosis. Part 2 is divided into 27 sections, each dealing with one or more specific congenital anomalies.

The Structure and Function of the Skin, by William Montagna. ($8.80. *Academic Press Inc., New York, N. Y.)* The author insists that biological phenomena will never be understood as long as one continues to speak of function and structure as two separate things. The skin is an ever-changing organ and many of its alterations are associated with changes in its morphology. The author points out that a knowledge of its histology, particularly its chemical cytology, should give greater significance to its physiology and biochemistry. This book belongs in the library of anyone who is at all interested in the skin.

Medical Parasitology, by William G. Sawitz, M. D. ($6.00. *Blakiston Division, McGraw Hill Book Co., New York, N. Y.)* This is a text for medical students and practicing physicians. The whole subject is presented from the medical viewpoint, to provide essential information necessary to the understanding of parasitic diseases.

Contemporary Psychotherapists Examine Themselves, edited by Werner Wolfe, Ph. D. ($6.75. American Lecture Series, published by *C. C. Thomas Co., Springfield, Ill.)* This is an evaluation of facts and values, based upon guided interviews with 43 representatives of the various schools of psychotherapy. It is particularly concerned with these questions: 1. To what extent does modern psychotherapy have a common terminology? 2. What are the main areas of agreement of the various systems? 3. What are the basic controversies concerning the use of the various techniques? 4. What is the proportion of success and failure with different types of patients? 5. What are the claims for effectiveness for the various schools of therapists? 6. What are the personality factors involved in the techniques, and the effectiveness of the various schools?

Culture and Mental Disorders, by George Linton. ($4.50. *C. C. Thomas, Company, Springfield, Illinois.)* The Sterling Professor of Anthropology at Yale University describes and analyzes mental disorders and abnormal behavior in various parts of the world. He brings to the subject an extensive knowledge gained in ethnological field work in Madagascar, Africa, in the Marquesas Islands, and among the American Indians, as well as in many years of teaching and research. During the last years of his life he had been conducting a research into the incidence of abnormal psychological states in primitive groups, with a view to determining how far psychoses and neuroses are affected by cultural conditions, and also to what degree physiological factors enter into the problem.

Virus Disease and the Cardiovascular System, by Ernest Lyon, M. D. ($5.75. *Grune & Stratton, New York 16, N. Y.)* The remarkable advance in our knowledge of virus diseases of man during the last 20 years has brought an accumulation of facts, data, and theories on associated vascular and heart involvement. Most of us do not have as great a perception of these complications in various infections as we should have. No comprehensive account of cardiovascular alterations in virus diseases can be found in any of the current textbooks on medicine; hence this survey is extremely valuable.

Signs, Symptoms, and Treatment of Certain Acute Intoxications, by Wm. B. Deichmann, Ph. D. ($2.00. *University of Miami Press, Coral Gables, Florida.)* This condensed symposium on poisons was designed for the use of interns and residents on emergency service at the Jackson Memorial Hospital in Miami, Florida. When an adequate presentation of poisons was made to the Pharmacy Committee of the Staff, it was evident that so many new poisons had been developed, such as insecticides and other toxic compounds in industry and as drugs, that even this brief summary, arranged for quick reference, would have to be put out in a volume by itself. Hence its appearance. It is a very handy book for a physician to carry in his bag or keep on his desk. It certainly belongs in the emergency room of every hospital.

Treatment of Heart Disease, A Clinical Physiological Approach, by Harry Gross, M. D., and Abraham Jezer, M. D. ($13.00. *W. B. Saunders Co., Philadelphia 5, Pa.)* The study of cardiac diseases has long passed the descriptive phase. It is now possible to determine the mechanism and symptoms and the efficacy of various forms of treatment. After long years of practice in cardiology and teaching the same to both graduate and undergraduate students, it seems to the authors that only by understanding these manifestations can the practice of cardiology reach the level of effectiveness made possible by advances in theoretical and experimental work. So

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the book is a presentation of the treatment of heart disease in terms of sound physiological principles.

Tumors of the Skin, by Herbert Conway, M. D. ($13.50. *C. C. Thomas Co., Springfield, Ill.)* This is a comprehensive text treating on known variations of tumors of the skin, and current methods of therapy. The book is profusely illustrated. Complete details are offered on physical examinations, life history, bibliography, and suggested details of surgical management.

Laughter and the Sense of Humor, by Edmund Bergler, M. D. ($5.00. *Grune and Stratton, Inc., New York 16, N. Y.)* In 1905, Freud published his monumental **The Wit and Relation to the Unconscious** which he never revised. Consequently, it does not reflect any of the psychoanalytical work of the past 50 years.

The author of this volume has brought up to date the theory of laughter and sense of humor. It is likewise an enlargement of his original studies of 1932 with Dr. Ludwig Jekels, the most brilliant of Freud's Old Guard.

Clinical Electrocardiology, Part I The Arrhythmias, by Louis N. Katz, M. D., and Alfred Pick, M. D. ($17.50. *Lea and Febiger, Philadelphia 6, Pennsylvania.)* The material which has accumulated since this text first appeared has compelled the authors to divide the subject into two separate volumes. The emphasis is still on the clinical import of this material. Arrhythmias have no complete book dealing with them and so they are presented in the first volume.

Sports Injuries Manual, by Donald F. Featherstone, M. C. S. P. ($6.00. *Philosophical Library, New York 16, N. Y.)* This book has been written for the coach or trainer who is a medical man. Fortunately, in addition to treatment and rehabilitation, the author has placed great emphasis upon precaution.

Health and Travel, ($3.00. *M. D. Publications Inc., New York 22, N. Y.)* This is the proceedings of the first international symposium on health and travel, under the chairmanship of Felix Marti-Ibanez. It deals with such subjects as, "When Children Travel"; "When People Who Are Not Young Travel"; "Infections in Travel"; "When Sick People Travel"; "Motion Sickness"; "Stress in Travel"; "Sea Travel and Health"; "The Medical Problems of Space Flight"; "The Physiological Day-Night Cycle after Long Test Flights"; "Nutrition in Travel"; "New Perspectives in Health and Travel."

Biochemistry for Medical Students, by William V. Thorpe, Ph. D. ($6.75. Sixth edition. *J. B. Lippincott Co., Philadelphia, Pa.)* The professor of clinical physiology at the University of Birmingham, England, has made major additions to the sixth edition of his text. These are in the area of protein structure, enzyme A and its role in metabolic processes. The entire chapter on enzymes has undergone extensive revision, and a chapter on redox potentials has been brought up to date. The section on nucleic acids has been entirely rewritten, as has the chapter on metabolic inter-relationships.

The Mentally Retarded Patient, by Harold Michal-Smith. ($4.00. *J. B. Lippincott Co., Philadelphia, Pa.)* The author, a clinical psychologist, offers here a provocative study of the problems involved in the management of the mentally retarded patient and his family. Since the physician often plays an all-important role in the recognition of the condition and coordination of the treatment of these patients, a thorough guide such as this will be of valuable assistance to him in his practice. An intelligence deficiency is not in itself an illness, but rather a psychological handicap which can result in a type of personality that presents special problems for the physician, the family, and the community at large.

Transactions of the American Goiter Association 1954-1955, John C. McClintock, Secy. ($14.00. *C. C. Thomas, Publishers, Springfield, Ill.)* Under the rules of the Society, all papers presented at the annual meeting appear in these Transactions, although they may also have appeared in the *Journal of Clinical Endocrinology and Metabolism*, or in some other journal. This volume, however, represents the complete proceedings of the meeting.

Diseases of the Nervous System, by Sir Russell Brain. ($11.50. Fifth edition. *Oxford Book Co., 224 Fourth Ave., New York 3, N. Y.)* The current edition presents new material on surgical spondylosis, the Coxsackie viruses, encephalitis, acute hemorrhagic leuko-encephalitis, toxoplasmosis, polymyositis, and the neuropathy and myopathy associated with carcinoma. The other chapters have been brought up to date.

Transvestism—Men in Female Dress, edited by David O. Cauldwell. ($3.00. *Sexology Corporation, 154 W. 14th St., New York 11, N. Y.)* This is the first authoritative work entirely devoted to a scientific interpretation of the matter, dealing with the origin and prevalence of transvestism.

Synopsis of Gynecology, by Robert J. Crossen, M. D. ($5.25. Fourth edition. *C. V. Mosby Co., St. Louis, Mo.)* Included are the new concepts of oogenesis and the development of the various ovarian structures, new ideas on the vascular mechanism controlling the functioning of the ovarian follicles, and recent advances in the cyclic histochemical changes within the cellular elements of the endometrium and the ovary. In addition, there are many new diagnostic techniques and a discussion of the importance of psychosomatic aspects of gynecological problems.

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JONATHAN FORMAN, M. D., *Editor*

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Asst. Managing Editor

Outline of Emergency Room Care of Wounds And Tetanus Prophylaxis

LEROY JAY HYMAN, M. D.

BECAUSE of a recent fatal case of tetanus that occurred in our hospital, (Mt. Sinai Hospital of Cleveland) the following facts and course of thinking were evolved with regard to this subject. This is our present approach to wounds and tetanus prevention. We feel that this outline should be made available to other physicians and hospitals who have not as yet formulated a newer, definite policy.

INCIDENCE

In World War II, in 2,800,000 wounded soldiers and sailors, there were but 16 cases of tetanus. Six of these 16 cases had received no immunization whatever; moreover, in no instance was antitoxin administered provided the patient had been immunized with a toxoid previously. With this overwhelming evidence of the efficacy of tetanus toxoid, it is the physician's duty to see that his patients are adequately immunized. With the absence of this generalized prophylactic program we now must face the problem of simultaneous active-passive immunization, and the use of the antitoxin with all the dangers that are involved.

BACTERIOLOGY

The causative agent, the *Clostridium tetani*, is a strict anaerobe and is a spore bearer. They are found in soil and in the gastrointestinal tracts of man and in domestic animals. Specifically, they may be found in feces, manure, hay, dust, horse hair, mortar and masonry, thorns, court plaster, garden soil and in any wound contaminated by fecal material.

Submitted January 2, 1957.

The Author

● Dr. Hyman, Cleveland, is senior visiting surgeon, Mount Sinai Hospital of Cleveland.

The spores require a low oxidation-reduction potential, and thus when injured or devitalized tissues are accompanied by foreign debris, the oxygen available may be sufficiently low to permit their germination. These wounds have no special characteristics, and the resulting infection is purely local. They may appear as a trivial injury and even to be well healed. However, the toxin by the tetanus is the most potent known neurotoxin there is next to the botulinus toxin.

The exact manner in which this toxin acts is still somewhat uncertain. The generally accepted thought is that the tetanus toxin is taken up at the peripheral nerve endings at the site of the infection. It is then taken throughout the body by way of the blood and presumably travels either within the nerve axis cylinders or in the perineural lymphatics to the motor cells of the spinal cord and cranial nuclei. It is in these latter two areas that the toxin is then presumably "fixed" in these cells and once located here it cannot be neutralized by antitoxin.

INCUBATION PERIOD AND PROGNOSIS

The incubation period varies from 2 to 30 days. The general consensus now is that the site of injury probably does not influence this period;

TYPES OF WOUNDS PRESENTED IN AN EMERGENCY ROOM AND GENERAL PRINCIPLES FOR THEIR CARE

Types of Wounds	Usual Causes	Local Wound Care
Contusions or bruises	Blows or crushing force not dividing skin	Reduction of congestion and control of bleeding by rest, elevation and support.
Abrasions or excoriations	Scratching, scraping or friction	Cleanse with soap and water followed by mild non-irritating antiseptic. Dressing with an antibiotic ointment.
Incised wounds	Knives, razors, glass, etc., producing gaping and bleeding wounds with clean wound margins.	Thorough irrigation with saline and cleansing with soap and water, shaving followed by mild antiseptic, sterilizing the surrounding skin as carefully as possible. Devitalized tissue or if impregnated with dirt should be excised by sharp dissection. Wound approximation then done without tension.
Constriction wounds	Cords, suction cups, etc.	Skin or facial incisions to relieve tension. Leave wound open.
Lacerated or contused wounds	From blows or falls. These include hammers, clubs, stones, cement, asphalt, car bumpers, wheel injuries, teeth or claws of animals, gunshot injuries.	Same principles of therapy as with incised wounds. Remove all foreign bodies. These wounds are more prone to tetanus.
Puncture and stab wounds	Needles, nails, ice picks, etc.	Cleanse to depth of wound. Leave wound open. These wounds also prone to tetanus.

Note: Discussion of vital organ damage, deep gunshot wounds and amputations omitted.

however, the incubation period may be prolonged if tetanus antitoxin has been given. The shorter the incubation period, the poorer the prognosis, particularly if it is less than seven days. If less than a lethal dose of toxin is combined with the tissue, a patient who has been treated adequately is likely to recover. Death is least likely to occur if the incubation period is longer than 14 days.

The diagnosis of tetanus is not too difficult in most instances. Usually within 12 days following the injury and infection, there is some muscular stiffness and soreness frequently accompanied by an awkward spastic gait, headache and insomnia. Then signs of cerebral excitation occur. The voluntary and involuntary muscles become rigid, followed by the classical trismus, pharyngeal spasm, opisthotonos, flexion of the elbows, extension of the knees, rectal and urinary sphincter spasm, etc. If acute tonic spasms occur they may become so severe as to cause cyanosis and evidence of asphyxia. Unfortunately, the victim remains conscious and exhaustion becomes a real thing.

CARE OF WOUNDS

The various types of wounds as they usually present themselves in an emergency room, and the general principles for their care are listed in the accompanying chart. Certainly, every physician should be well grounded in the many detailed aspects surrounding these topics, and should have a good knowledge of the various types of wounds, including projectiles, glass injuries, burns, use of moist and wet dressings, rapid means of controlling hemorrhage, use of suture materials, avoiding disfiguring scars, the use of drains, et cetera.

GENERAL PRINCIPLES FOR ALL TYPES OF WOUNDS

In all cases, the treatment of any shock should precede all local wound therapy with the exception of hemorrhage arrest.

Bacteria may rapidly penetrate beneath the surface of an open wound, and thus strong antiseptics may devitalize the tissue setting up a good nidus for infection.

A wound contaminated by tetanus does not suppurate except by association with other bacteria.

The proper surgical care of the wound must include the removal of only devitalized tissue and foreign material.

Wide debridement may be harmful.

Suturing when necessary must be done carefully.

If the tissue appears to have poor vitality or where gas gangrene or any serious infection may occur, leave the wound open.

Drain where bleeding may not be completely controlled or where wound fluid may collect or when severe infection is expected.

Wound dressings should not constrict and a layer of sterile gauze with a supporting bandage is usually sufficient.

All wounds should be inspected within 24 to 48 hours.

TETANUS PROPHYLAXIS BY MEANS OF TOXOID OR ANTISERUM

1. All adults and children whose last tetanus toxoid injection was within a four to five year period need be given only a booster of tetanus toxoid. The fluid toxoid causes a more prompt increase in agglutinin titer and is preferred for the booster injection. In contrast, the alum-precipitated toxoid provokes a superior initial response for those being immunized for the first time.

2. With those individuals whose last tetanus toxoid injection was given more than four years previously, a booster dose should also be given. In this group one can expect that within 14 days almost 100 per cent will have protective levels of antitoxin. In these cases, if the physician is

particularly concerned with the type of wound involved, then one may at the same time administer 1,500 units of antiserum at another site from where the toxoid was given. Antiserum doses in excess of this amount may interfere with the active immunizing stimulus of the toxoid.

3. In those cases in which there has been no previous immunization of any kind it is best to give active-passive immunization using 1,500 units of antitoxin and starting the first injection of toxoid. However, in those cases where the lesion may be very dangerous from the standpoint of tetanus, it is best to delay for several days in the administration of the indicated booster dose of toxoid since 1,500 units of antiserum is probably not sufficient. In these cases, one must consider giving up to 10,000 units of antitoxin. Furthermore, if the case is that suspicious, the surrounding tissue had best be injected with 10,000 to 20,000 units of antitoxin directly about the wound.

4. While skin testing is very essential, it must be remembered that a negative test does not rule out the later development of serum sickness. Serum sickness may be a very serious complication, and consequently all these cases must be carefully followed. If the sensitivity tests are positive, it is essential that all the details and instructions as contained in the brochures accompanying the vials of antiserum are carefully carried out.

5. In those cases where antiserum has been used, it is probably best to also administer penicillin, since it has been shown that there are definite beneficial effects from its antibiotic properties against the *Clostridium tetani* in eradicating the organism from the portal of entry within one to four days.

SUMMARY

Patients who have been immunized within four to five years need receive only a booster dose of the fluid toxoid. This is true also for those individuals who have been immunized within the past 10 years provided the wound is not too suspicious, in which case 1,500 units of antiserum may also be administered. Finally, in those patients who have not been previously immunized and in whom there is a very likely source of tetanus, then one must go all the way in the use of large doses of antitoxin as well as its use directly in the surrounding tissues about the wound.

Despite these measures which have been described for use in our emergency room, there is still a need for very careful individual judgment and discretion in the prophylaxis of potential tetanus contaminated injuries in those who have had no toxoid immunization. The blanket use of 1,500 units of antitoxin in all individuals without a complete understanding of the origin of tetanus, the handling of wounds, the efficacy of toxoid, its inadequancy in the most serious wounds is not a measure to be condoned.

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Smog Survey Emphasizes Dangers From Air Pollution

Irritation of the eye and respiratory tract, chest pain, cough, shortness of breath, nausea—all are recognized as symptoms of poisoning from smog, according to a consensus of members of the Los Angeles County Medical Association. Anesthesiologists, gastroenterologists, chest physicians and pathologists expressed themselves 100 per cent as recognizing these symptoms as a "smog syndrome."

The majority of physicians who replied to a questionnaire prepared by the Smog Committee reported that individuals have left the Los Angeles area because of smog and that a good percentage actually have advised their patients to leave. Further, many physicians advise their patients how to protect themselves from smog. Dr. Francis M. Pottenger, Jr., Chairman of the Smog Committee, pointed out that 95 per cent of those physicians most closely associated with neoplastic disease—pathologists, roentgenologists and men specializing in its care—are in agreement that cancer can result from air pollution.

Patients with respiratory diseases are more susceptible to smog than healthy adults according to 100 per cent of the gastroenterologists, 86.7 per cent of the chest men and 80.5 per cent of the eye, ear, nose and throat specialists. Patients with cardiac disease also appear to be more susceptible to smog than healthy adults. Expressing themselves definitely, 68.1 per cent said Yes; 31.9 per cent said No.

Other groups particularly susceptible to smog include patients with anxiety states, allergies and the aged. Eighty per cent of the public health physicians, 76.1 per cent of the neuropsychiatrists and 78 per cent of the ear, nose and throat men feel that smog has a definite effect on anxiety states. Reports were even more overwhelming concerning allergies. Of the allergic group 92.7 per cent of the ENT men, 90 per cent of the allergists, 81.6 per cent of the ophthalmologists and 83.3 per cent of the gastroenterologists felt that allergic patients were more susceptible. Of the definite opinions 75.2 per cent of the physicians said smog had a decided effect on the aged. POTTENGER, F. M., Jr.: Results of LACMA Smog Survey, *Bulletin*, Los Angeles County Med. Assoc., 87:33 (April. 18) 1957.

The Pierre-Robin Syndrome: An Acute Airway Problem in the Newborn

JOHN C. TRABUE, M. D., and BRUCE C. MARTIN, M. D.

INTRODUCTION

THE Pierre-Robin syndrome consists of a triad of congenital anomalies: micrognathia, macroglossia and midline incomplete cleft palate. It is of particular clinical interest in as much as the airway is involved and early recognition is mandatory to prevent sudden death in the newborn. The hypoplastic mandible (micrognathia) alone can be the source of airway obstruction; however when combined with the above associated deformities the problem gains potential.

Congenital cleft of the palate occurs in approximately one out of every seven hundred births. Twenty-five per cent of these children involved with congenital failure of fusion between the maxillary and frontonasal processes have involvement of the lip alone. Fifty per cent have associated cleft palate and cleft lip. The remaining 25 per cent have involvement of the palate alone. This may involve only the soft palate or a portion of the hard palate. In any event, the alveolar arch and the lip are not involved. It is with this latter group that we are concerned in this paper for the anomaly is frequently not immediately recognized.

It is usually first diagnosed by the attendant in the nursery who visualizes the child's palate in hard crying or as undue regurgitation of milk into the nose is encountered at the time of the first feeding. Not infrequently the syndrome complex is first diagnosed by an unexplained episode of rather severe cyanosis as the baby lies supine in the crib. It is also of interest to note that in the group of midline incomplete cleft palates, five cases will occur in the female to two in the male, therefore the Pierre-Robin syndrome is most frequently seen in the female.

ANATOMY

Micrognathia designates a hypoplastic mandible. This, of course, occurs in varying degrees and may or may not be associated with the other two factors comprising the syndrome under discussion. When the underdeveloped mandible is associated with an unduly large tongue (macroglossia), the genioglossi muscles coursing from the symphysis of the mandible to the root of the tongue, fail to hold the tongue forward into correct position and thereby permit ptosis or retroposition of the tongue in such a manner as to obstruct the airway. The tongue not only falls back to obstruct the hypopharynx, indeed, it occasionally comes down to act with ball valve effect over the epiglottis. It thereby permits egress of air and denies ingress of air. This is clinically manifested by marked sternal retraction.

The retropositioned abnormally large tongue also impinges upon the posterior pharyngeal wall to excite the urge to regurgitation. This dysphagia is manifested by excessive mucus in the hypopharynx and frequent episodes of vomiting. This, of course, may lead to aspiration pneumonia which is the most common source of morbidity in unmanaged cases.

TREATMENT

Immediate management is contingent upon a patent airway both with the child sleeping and in alert crying conditions. Placing the infant in a so-called postoperative position, that is, with the child lying on its side or abdomen with the mouth in the dependent position, will permit the tongue to fall forward and allow satisfactory respiratory exchange. Placing the infant in a supine position is entirely unsatisfactory.

An indwelling airway will serve to hold the tongue forward but as an extraneous artifice this is not satisfactory over a prolonged period of time. Tracheotomy in a newborn is heroic treatment to say the least and mortality is much too high to permit its utilization in combating such obstruction of the nasopharynx. Repair of the cleft of the palate as advocated by some is usually of insufficient strength to hold the rather massive tongue in a forward position. In addition, repair of the palate in the newborn is a considerable surgical undertaking which involves a structure important in the function of speech in later life and it is the feeling of the authors

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that tampering with the important structure at this stage is contraindicated.

The operation as proposed by Douglas[1] has been found satisfactory in holding the tongue forward. This, in effect, is a surgical tongue tie. The inferior surface of the tongue is denuded, a strip of mucous membrane approximately 1.5 centimeters in width being removed over the course of the entire inferior surface of the tongue into the lingual sulcus, up over the alveolar ridge, down into the buccal sulcus and out onto the lower lip. This denuded pathway is then sutured together bringing the tip of the tongue well forward and if possible beyond the most convex portion of the tip of the lower lip. The tongue is held into position by a single through and through suture from the lower lip through the base of the tongue and back again and tied over bolsters to hold the tongue forward.

The latter operation is comparatively simple. It satisfactorily holds the tongue forward to restore the airway and prevent contact with the posterior pharyngeal wall. The created surgical adhesion is permitted to exist for a period of approximately ten months after which time normalcy is restored by a Z-plasty to the mucous membrane in the buccal and lingual sulci.

The long term rehabilitation of the micrognathic patient is primarily a problem of orthodontia. Early in the infant's life cephalometric x-ray studies are taken as a baseline and subsequent cephalometrograms are read as growth proceeds. No artifices are indicated to "stimulate" hypertrophy of the mandible as previously advocated by numerous authors. Following eruption of the teeth, occlusion is studied by models taken from dental impressions. It is most gratifying and in the majority clinically anticipated that growth of the mandible will, in effect, "catch up" with the maxillary growth and the less interference inflicted upon the growing infant, the better the end result.

The cleft palate, for reasons now widely documented, is repaired when the infant is approximately 18 months of age. This has to do primarily with speech rehabilitation. Insofar as the infant has a vocabulary of approximately nine words at 18 months in contrast to a vocabulary of several hundred words at three years of age, it is deduced that the majority of speech habits are being learned during this age group. While the persistent cleft palate permits an abnormal physiological state to the mucous membrane in and about the eustachian orifices with minor obstruction symptoms such as conductive hearing loss of 15 decibels or less, it is felt that definitive surgery upon the palate should be deferred until the youngster is at least 18 months of age in order to achieve the all important factor of definitive repair at the initial surgical attempt.

Feeding the youngster with the cleft palate, while frightening to the mother in the initial stages, is usually early overcome by enlarging the hole in the nipple to enhance the flow of milk. Failing in this, the so-called Breck feeder can be utilized. This is a short length of rubber tubing attached to the end of a syringe. Only the rare case requires hospitalization for reasons of nutrition. When hospitalization is required, gavage by nasal intubation is usually employed. It is important to caution the mother to hold the child in a semi-sitting position when feeding the youngster with a cleft palate in order to minimize the possibility of flow of milk into the eustachian tubes.

SUMMARY

Early recognition is the all important factor in the management of the so-called Pierre-Robin syndrome. This syndrome is composed of macroglossia, micrognathia and midline incomplete cleft palate. The three congenital anomalies combine to obstruct the airway of the infant at the level of the hypopharynx. Death may rapidly occur because of obstruction of the airway or aspiration pneumonia which results from regurgitation accruing from undue irritation of the posterior pharyngeal wall by the macroglossia.

Conservative measures are to be employed initially and perhaps these could be described best as watchful management. When a single episode of cyanosis occurs, the physician should seriously consider surgical intervention. Surgery consists of a creation of an artificial tongue tie which holds the tongue in a markedly advanced position. When mortality ensues, it is usually because the complex has been unrecognized or the ensuing morbidity such as aspiration pneumonia overwhelms the patient.

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Volvulus of the Sigmoid*

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VOLVULUS of the sigmoid is a serious clinical problem because it commonly occurs in the aged and because the circulation of the bowel is often compromised before appropriate therapy is achieved.[4, 8, 9]

Between the years 1943 and 1955 ten patients with this condition were encountered at City Hospital of Cleveland with a hospital mortality of 40 per cent. Examination of the factors related to this high mortality pointed to certain principles which although not new are thought to be worthy of emphasis and form the basis of this report.

All 10 patients were male, in keeping with the generally accepted fact that volvulus of the sigmoid colon is much more common in this sex.[3] All four of the patients who died had had gangrene of the sigmoid colon. Only one of the six who survived had developed gangrene (table 2). The ages did not differ between the two groups (table 1). Hence, age alone was not the important factor.

TABLE 1.—PATIENTS WHO DIED FROM VOLVULUS OF THE SIGMOID COLON

Age	Gangrene Present	Operation
83	Yes	Yes
82	"Dusky bowel"	Yes
71	Yes	Yes
64	Yes	None

TABLE 2.—PATIENTS WHO SURVIVED VOLVULUS OF THE SIGMOID COLON

Age	Gangrene Present	Emergency Operation	Reduction with Barium Enema and Sigmoidoscopy
81	No	No	Yes
64	No	No	Yes
63	No	No	Yes
61	Yes	Yes	No
56	No	No	Yes
22	No	No	Yes

Examination of the abdomen by the plain roentgenogram is an accepted adjunct to the clinical appraisal of the patient with ileus, and frequently the appearance is sufficiently characteristic to warrant a diagnosis of volvulus of the sigmoid.[5] It must be emphasized, however, that lack of roentgenologic signs does not rule out volvulus of the sigmoid (table 3). Thus, in four of the nine patients examined by this means the appearance of the plain abdominal roentgenogram did not suggest volvulus even in retrospect. In three of the four the appearance was that of mechanical obstruction, presumably secondary to a tumor of the descending colon; the fourth was described as paralytic ileus.

In five of the nine patients examined radiologically, the plain film of the abdomen was either characteristic or highly suggestive of volvulus of the sigmoid. It is interesting, however, that

TABLE 3.—PREOPERATIVE EXAMINATION BY X-RAY

Case Number	Age	Interpretation of Roentgenograms	Barium Enema	Gangrene
1	83	Paralytic ileus	Not done	Present
2	82	Volvulus of sigmoid	Used	Present
3	81	Suggestion of volvulus of sigmoid	Used	Absent
4	71	Mechanical obstruction of large bowel due to 2° carcinoma	Not done	Present
5	64	Mechanical obstruction of large bowel due to 2° carcinoma	Not done	Absent
6	64	None made. Clinical diagnosis: Uremia	Not done	Present
7	63	Volvulus of sigmoid	Used	Absent
8	61	Obstruction of large bowel by carcinoma	Used*	Present
9	56	Volvulus of sigmoid	Used	Absent
10	22	Volvulus of sigmoid	Used	Absent

* Incorrectly interpreted.

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this was true in only one of the five patients who had impaired circulation of the sigmoid colon. In the other four of this group the appearance suggested either paralytic ileus or mechanical obstruction of the descending colon.

In four of the five patients in whom the correct clinical diagnosis was either strongly suspected or established, the sigmoid volvulus was reduced by diagnostic sigmoidoscopy and barium enema. Elective resection was performed at a later date (table 4).[2,5,7,9] In the fifth patient,

TABLE 4.—CASES OF SIGMOID VOLVULUS REDUCED BY BARIUM ENEMA AND SIGMOIDOSCOPY

Case Number	Age	Outcome
3	81	Elective resection with survival
5	64	Negative exploration for carcinoma of sigmoid colon
7	63	Elective resection of sigmoid with survival
9	56	Elective resection of sigmoid with survival
10	22	Elective resection of sigmoid with survival

the volvulus, in retrospect, was reduced by diagnostic sigmoidoscopy and barium enema, but the fact that it had existed was not recognized; the findings by barium enema were misinterpreted, and a laparotomy was performed for obstructing carcinoma of the sigmoid colon.

DISCUSSION

The importance of strangulation in relation to the prognosis in intestinal obstruction is well known.[10] In this group of 10 patients with volvulus of the sigmoid none died who had not developed gangrene or pre-gangrene as the result of strangulation. Of those who developed gangrene, however, four of the five did not survive. With one possible exception (Case 2, table 1) all five patients had developed gangrene prior to hospital admission. The examining physician, therefore, must not temporize and delay hospitalization in the patient with intestinal obstruction because, although uncommon as a cause of obstruction, volvulus cannot be excluded and delay can lead to gangrene from strangulation.

Plain roentgenograms of the abdomen with ileus can suggest a diagnosis of volvulus of the sigmoid with varying degrees of certainty. The lack of characteristic roentgen findings, however, does not rule out the condition. This is particularly true in patients who have already developed gangrene (table 3).

In all patients with complete large bowel obstruction without signs of peritoneal irritation, sigmoidoscopy should be done just as soon as the patient can be prepared for the procedure in order to establish or rule out the diagnosis of sigmoid volvulus. When findings consistent with strangulation are encountered, the examination is discontinued and laparotomy is performed.

When plain roentgenographic findings are typical of uncomplicated volvulus of the sigmoid an attempt can be made to reduce the volvulus by sigmoidoscopy and barium enema while confirming the diagnosis. Reduction of the uncomplicated sigmoid volvulus can be accomplished quite satisfactorily by these means if care is exercised and the inherent danger of perforation recognized.[1,4,6] With the volvulus reduced, the fear of gangrene no longer exists and definitive surgery can be performed at a later date provided that reduction is maintained by repeated sigmoidoscopy if necessary.

It is worth emphasizing again that the diagnosis of sigmoid volvulus must not be dismissed in favor of mechanical obstruction of the colon on the basis of the plain roentgenogram of the abdomen without the supplementary aid of sigmoidoscopy and barium enema. By so doing the diagnosis of volvulus can be missed and strangulation may occur as the result of delay.

CONCLUSIONS

1. Volvulus of the sigmoid colon is a serious disease not only because of the intestinal obstruction it produces but also because of the frequency with which it is complicated by strangulation and infarction.

2. Delay of diagnostic procedures in patients with large bowel obstruction can delay the diagnosis of volvulus of the sigmoid until gangrene develops with its attendant high mortality.

3. The plain abdominal roentgenogram is inadequate for excluding volvulus of the sigmoid. Sigmoidoscopy and barium enema should be done in patients with mechanical obstruction of the large intestine unless contraindicated by signs of infarction or peritonitis.

4. Sigmoidoscopy and barium enema are useful not only as diagnostic aids, but also as therapeutic measures. In simple volvulus they can produce detorsion of the bowel thereby permitting delay of definitive treatment to an elective time.

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A CONTINUOUS state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and assisted by official representatives of the various County Medical Societies of the state.

Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, will be published in *The Ohio State Medical Journal* from time to time. Each presentation will be brief but informative. It will contain opinions of the Committee, based on the data submitted for review. The three cases in this twelfth report concern maternal death due to hemorrhage.

CASE NO. 93

This patient was a 34 year old Negro, Para III (?), who was admitted to the hospital 8 p. m., October 6 without prenatal care, in active labor and died three hours postpartum. There is nothing in the record about her present pregnancy, past obstetrical history or general health. It is presumed she was near term.

She had a rapid multiparous labor and at 8:30 p. m. the membranes were bulging the perineum. These were ruptured and the cord and a hand prolapsed. There is no record that a rectal or vaginal examination had been done to determine the extent of cervical dilatation or that an attempt had been made to diagnose position by abdominal palpation. The attending physician then did an internal podalic version under ether anesthesia administered by a registered nurse.

Tremendous difficulty was experienced with delivery of the after-coming head and the patient went into shock before the delivery was completed. A normal sized baby was born at 9:45 p. m. It died during delivery. The patient was placed in Trendelenburg position at once and given oxytoxics and oxygen without avail. She had little vaginal bleeding and expired at 12:30 a. m., October 7. An autopsy was performed.

Pathological Diagnosis: The cause of death from the coroner's report was hemorrhage into the peritoneal cavity resulting from a circular laceration of the corpus which nearly separated the uterus from the cervix and vagina.

COMMENT

The Committee voted this a preventable death and felt that the management of this patient was inadequate. Even if one concedes that delivery through the vagina in a case of this kind under the most favorable conditions is the procedure of choice one is still at a loss to understand the complete absence of efforts to discover the cause of the shock and treatment of it. A pelvic examination would have revealed the results of the traumatic delivery. Possibly blood replacement and immediate surgical intervention might have altered the patient's course though this is doubtful with an injury of this magnitude. *Prevention* is the essence of management in cases of this kind; serious consideration should be given delivery by the abdominal route if this was a transverse lie of the fetus, as assumed from the prolapsed hand and cord. Certainly consultation was indicated.

CASE NO. 94

This patient was a 37 year old white, Para VI, Abortus I, who died six hours postpartum. Her first pregnancy had terminated in a spontaneous abortion at 12 weeks. The next five pregnancies had resulted in five full term living children delivered by low forceps over episiotomies with uncomplicated postpartum courses. She had had adequate prenatal care during this pregnancy since the third month. Her blood was type O Rh-positive and the serologic test for syphilis was negative. There had been no abnormalities with this pregnancy and the onset of labor was spontaneous, October 9th, at 37 weeks' gestation.

The patient was making apparently normal progress in her labor being 4 cm. dilated and having contractions at two minute intervals lasting 50 seconds. At this time she was given Pituitrin® 1/10 cc. intramuscularly and the membranes were artificially ruptured. One hour and fifteen minutes later the patient was fully dilated. She was given Pituitrin 1/10 cc. intramuscularly and taken to the delivery room. Premedication was Demerol,® Tuinal,® and scopolamine. The delivery was uneventful with low forceps over a mid-line episiotomy with the patient under anesthesia given by a physician, (type not known).

There was no note of blood pressure reading at the conclusion of the delivery, but the pulse was reported as satisfactory when the patient was transferred to her bed. Slight vaginal bleeding continued. Fifty minutes after delivery the uterus is said to have relaxed with the loss of 200 to 300 cc. of blood and the patient went into

shock with a blood pressure of 70/40. She was immediately started on fluids, Adrenalin,® Coramine® and blood without improving. One and one-half hours later the attending physician arrived and packed the vagina. From that time on the patient was given six pints of blood, oxygen, fibrinogen and stimulants without avail. She expired at 5:20 a. m., Oct. 10, six hours after birth of the baby. Autopsy permission was granted.

Pathological Diagnosis: Ruptured uterus with the tear long enough to admit the clenched fist extending from 4 cm. below the ovarian ligament down through the cervix into the vagina. There was free, recent unclotted blood in the peritoneal cavity.

COMMENT

The Committee felt that this was a preventable maternal death resulting from the injudicious use of Pituitrin in a grand multipara. It appeared that this patient was in extremely active labor, making excellent progress and that the administration of Pituitrin under these conditions could be interpreted only as meddlesome obstetrics. Members felt Pituitrin should never be used in the first or second stage of labor in a grand multipara because of the uterine fibrosis which exists; rupture occurs considerably more frequently than in patients of lesser parity.

The Committee also felt that in the presence of shock with a patient bleeding, a vaginal examination is mandatory, prior to packing. The Committee doubts very seriously that packing is really useful and believes that vaginal packing only conceals—does not control bleeding. The possibility of increasing an existing laceration is very real.

The free unclotted blood in the peritoneal cavity makes one think of the possibility of amniotic fluid embolism with the resulting afibrogenemia which has been so frequently seen by the Committee and previously reported in the April 1957 issue of *The Journal*. Apparently the attending physician also considered this possibility since the patient was given fibrinogen.

CASE NO. 125

This patient was a 25 year old Negro, Gravida I, who died three and three-fourths hours postpartum (post-cesarean). She entered the hospital at 38 weeks on December 7 about 9 p. m., in early labor. Her prenatal care as recorded consisted of three visits occurring in the third, fourth and fifth months of gestation. At these times the findings were not abnormal except for a blood pressure reading of 160/90 which occurred in the fourteenth week of pregnancy. We are not told why this apparent hypertension was not made the basis for further investigation or at least observation. At the first examination in the hospital the patient's weight was 170 pounds, the blood pressure 150/100, the hemoglobin 9.9 grams and the fetal heart tones 146.

The patient continued in labor making apparently normal progress for a primigravida until 12:02 a. m. when the attending physician was notified of the patient's condition. He was called again at 2:15 a. m. and at 3:00 a. m. and on each occasion the patient's vaginal bleeding was reported. He arrived at the hospital at 3:45 a. m. At this time the patient's blood pressure was 100/70, the uterus was tense and there were no fetal heart tones audible. A diagnosis of premature separation of the placenta was made and a telephone consultation was held.

A cesarean section was decided upon and the general anesthetic (clyclopropane) was started by a physician anesthetist at 5:45 a. m., Dec. 8. The patient's condition at this time was described in the record as poor. At 6:25 a. m. the patient was given ephedrine, and at 6:30 a. m. 500 cc. of whole blood was started. A Levophed® drip was also started. The blood transfusion was finished at 7:05 a. m. and the low cervical cesarean section was completed at 7:20 a. m. The stillborn baby was delivered at 6:15 a. m., sex and weight not reported.

At 7:45 a. m. the patient was partly conscious. At 8:15 a. m. the blood pressure was 80/60 and 500 cc. of *saline* plus 500 cc. of blood was started. The patient's condition rapidly deteriorated in spite of Neo-Synephrine® and other stimulants. She went rapidly down hill and was pronounced dead at 10:00 a. m. No autopsy.

Cause of Death: Acute shock (7 hours); Acute hemorrhage; Abruptio placenta (7 hours); Pregnancy 38 weeks, delivered.

COMMENT

The Committee considered this a preventable maternal death; the treatment can be most succinctly described as "too little and too late." The Committee could not consider the prenatal care adequate and there was no record that anyone paid attention to this patient's apparent pre-eclampsia.

Further, in spite of an admitting hemoglobin of 9.9 grams no blood was given until at least four and one-half hours after the onset of bleeding and then only a total of 500 cc., with another 500 cc. two hours later. Neo-Synephrine, ephedrine and Levophed are valuable therapeutic agents. Nothing takes the place of blood in the presence of hemorrhage and one should always think in terms of blood replacement, not just transfusion. When hemorrhage occurs in an anemic patient this is even more important. The Committee felt local infiltration would have been a more desirable anesthetic for surgery; telephone consultations leave much to be desired!

COMMENT OF CONSULTANT

The following comment of a consultant, who is a specialist in obstetrics and gynecology, was given at the request of the Committee.

It's the same old story year after year—women dying from "unrecognized" rupture of the uterus. Shock, with or without external hemorrhage, demands manual exploration of the uterus and careful visualization of the cervix and vagina. Any unusual obstetrical procedure as version, resistant after-coming head, difficult mid-forceps, etc., should be followed by manual examination of the uterus after placental expulsion.

Podalic version fortunately has been greatly replaced by caesarian section but, when done in rare instances, the operator must prove to his satisfaction that the procedure has not ruptured

the uterus. If we can always link the two terms, version and uterine rupture, in our minds, many such uteri will be recognized before the old story of deepening, irreversible shock.

One word on the use of a pituitary oxytocic. Grand multiparity is a distinct contraindication, and active labor (contractions every two minutes lasting 50 seconds as in case No. 94) is always a risk to pituitary stimulation. The amount of oxytocic is not important. It is the patient's reaction to the drug. One-half minim in one case will cause a long, tetanic contraction with anoxia to the fetus, etc., while half a cc. to another will have no effect.

Uteri will rupture or be ruptured in dystocia cases. That is not so much the sin as failure to look for and recognize it. Keeping the possibility of such a serious complication always in mind will save maternal lives.

Allergic Implications of Blood Disorders in Infancy

The clinical manifestations of many of the blood disorders are wholly or partially dependent on immunoallergic reactions. A growing body of evidence permits the characterization of antigen-antibody mechanisms in connection with hemolytic anemia, purpura and agranulocytosis, and more specifically for each of the blood cell elements and for the vessel wall.

These reactions extend to maternal-fetal relationships producing well defined blood disorders manifest at birth or in the neonatal period.

Once the effects of the hypersensitive state are set in motion during the course of a blood disorder, therapeutic measures to slow their progress are often futile. Because it is not always possible to identify the potentially allergic child in whom these circumstances will occur, it is extremely important to weigh the advantages of the use of a drug before it is administered especially when its side effects have not yet been thoroughly investigated.—Carl H. Smith, M. D., New York City: *California Med.*, 86:366, June, 1957.

Dry Ice Poisoning

The National Safety Council reports that carbon dioxide in 10 per cent concentration may produce unconsciousness and that larger quantities may cause death by suffocation.

Dr. Walter cited a case report of an adult man and his mother who were overcome by carbon dioxide intoxication while driving in a car with windows closed. In the back of their car they were transporting 60 gallons of ice cream sealed in cartons packed with 100 pounds of dry ice. "Dealers in dry ice should be alerted to this danger and should warn customers to have adequate ventilation in cars carrying dry ice." WALTER, A. L.: Carbon Dioxide Intoxication, *Missouri Medicine* 54:436 (May) 1957.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met at Mount Carmel Hospital in Columbus on Wednesday, July 31, at 12 o'clock noon, and presented the following two cases before the general staff meeting of Mount Carmel:

Case No. 1: The patient, aged 54, Gravida II, Para II, had uneventful menopause at the age of 47. Four years postmenopausally patient began bleeding. She saw her physician who gave her "shots" to control the bleeding for three years. At times the response to the shots was good and other times, not. No pelvic examination was done during this time.

The patient then changed physicians. A pelvic examination and papanicolaou smear were done and the patient was referred to clinic. Patient required four units of blood for transfusions in order to correct anemia. A dilatation and curettage and biopsy were done. Pathological report was adenocarcinoma, Grade III malignancy. Therapy was given in the form of intracavitary radium, 4320 milligram hours.

The patient was re-admitted one month later for a total hysterectomy, bilateral salpingo-oophorectomy. She had an uneventful recovery. One year postoperatively patient was seen and was doing well.

COMMENTS

(1) Three years physician delay.

(2) No pelvic examination was done while patient was bleeding.

(3) Postmenopausal bleeding is abnormal and an examination should definitely be done.

Case No. 2: The patient was admitted with the chief complaint of intermittent vaginal bleeding, first noted three years before. During the three years she had been treated by several doctors who gave her shots. No pelvic examination was done until she saw the physician who took the papanicolaou smears and when the report came back suspicious, he referred her to clinic.

Menopause, 47 years. Examination revealed marked obesity. Pelvic examination revealed a relaxed introitis and vagina with a clean normal positioned cervix. No masses were felt. Patient had a dilatation and curettage and biopsy of the cervix. Large amounts of friable endometrial tissue were obtained and the pathological report was papillary endometrial adenocarcinoma, Grade III malignancy. She received a total dosage of 4,800 mgm. hours of radium.

Two months later the patient had a total abdominal hysterectomy and bilateral salpingo-oophorectomy. Pathological report was residual endometrial adenocarcinoma, Grade II malignancy.

COMMENTS

(1) Three years physician delay.

(2) No pelvic examination was done while patient was bleeding.

(3) Postmenopausal bleeding is abnormal and an examination should definitely be done.

An Unusual Case of Bacterial Resistance to Antibiotics With Successful Reversal by Use of Isonicotinic Acid Hydrazide and Para-Aminosalicylic Acid

WALTER L. GEORGE, M. D., and STEVEN ZSAKO, M. D.

IN this modern era of antibiotic therapy the clinician has come to fear bacteria which have become resistant to commonly used antibiotics. It is just such a case that we present here.

The protocol is that of a 47 year old white male who was admitted to Euclid-Glenville Hospital on February 17, 1956, following a serious automobile accident. On admission to the hospital the following abnormalities were noted:

1. Cerebral concussion with partial amnesia.
2. Severe crush injury of the chest.
3. Multiple fractures of the second to the sixth anterior ribs of the left side.
4. Fractures of all the extremities: right and left ulna; right femur and tibia; left tibia and patella.
5. Deep lacerations of the left side of the face, forehead, and right forearm.

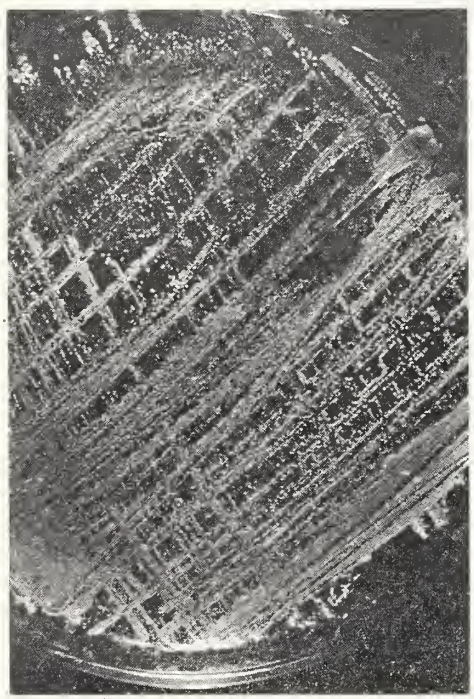
The Authors

● Dr George, Cleveland, is a member of the active staff, Department of Internal Medicine, Euclid-Glenville Hospital, and Department of Internal Medicine, Euclid Clinic Foundation.

● Dr. Zsako, Cleveland, is medical resident, Cleveland Clinic Foundation.

Irradiated whole blood

↓



↑

Non-irradiated whole blood

Plate 1. Irradiated whole blood added to culture plate failed to produce any clearing of bacterial colonies.

Submitted September 7, 1956.

The blood pressure at the time of arrival was 170/110. This fell quickly so that intravenous fluids and blood transfusions were necessary to stabilize the blood pressure at the level of 110/70. As soon as the blood pressure could be maintained a tracheotomy was performed because of respiratory difficulty. The patient was then placed under an oxygen tent in an atmosphere of cold steam.

On the third hospital day the pulse became very irregular and moist rales could be heard over the base of the right lung. At this point the patient was rapidly digitalized and placed on a maintenance dose. Simultaneously, diuretics were instituted. Following this the patient compensated rapidly.

On the ninth day in the hospital the patient developed tenderness in the left upper quadrant of the abdomen and the hematocrit dropped suddenly. A splenic subcapsular hematoma was suspected. A program of careful observation was pursued because of the serious clinical condition of the patient. Within three days, the abdominal tenderness subsided and the hematocrit which was corrected by the whole blood transfusions showed no further drop.

From the first hospital day on, the patient ran a febrile course of a daily oral temperature peak of 100° Fahrenheit. Within 24 hours the white blood count had risen to 17,000 but within the next 21 days it dropped slowly to 6,000. At all times there was a marked preponderance of polymorphonuclear cells.

At the very onset the patient was placed on procaine penicillin 400,000 units every six hours and streptomycin 0.5 gram every 12 hours intramuscularly. On the eleventh hospital day, because of the persistent fever, these drugs were

discontinued and the patient was placed on Terramycin® 250 mgm. every four hours orally without improvement.

ISOLATION OF ORGANISMS WHICH DEMONSTRATED MORPHOLOGICAL ALTERATIONS

On the twenty-second hospital day the patient suffered severe chills and displayed a septic type of temperature which rose from a base line of 100° to a peak of 104.2°F. At this point blood cultures were drawn and hemolytic Staphylococci were isolated from the blood stream. Microscopic studies revealed that these organisms were slightly smaller than usual and showed some tendency toward a gram-negative stain. It was our conclusion that these organisms had been changed by some environmental factor in the past, very likely antibiotics.

ISOLATION OF ORGANISMS WHICH DEMONSTRATED UNUSUAL RESISTANCE TO ANTIBIOTICS

Antibiotic sensitivity tests were then initiated whereupon we discovered that our isolated strain of staphylococci was resistant to almost every commonly known antibiotic. The accompanying table 1 summarizes our sensitivity tests.

The table is based on the degree of clearing

TABLE 1.—SUMMARY OF ANTIBIOTIC SENSITIVITY TESTS

Antibiotic	Strength of antibiotic	Sensitivity
Penicillin	1 mcg.	None
Penicillin	10 mcg.	None
Streptomycin	10 mcg.	None
Streptomycin	100 mcg.	None
Chloromycetin®	2 mcg.	None
Chloromycetin	20 mcg.	Very slight (0.6 mm.)
Aureomycin®	2 mcg.	None
Aureomycin	20 mcg.	None
Terramycin®	10 mcg.	None
Terramycin	100 mcg.	None
Erythromycin	10 mcg.	None
Erythromycin	100 mcg.	None
Panmycin®	30 mcg.	None
Achromycin®	10 mcg.	None
Achromycin	30 mcg.	None
Achromycin	60 mcg.	None
Tetracyn®	10 mcg.	None
Tetracyn	30 mcg.	None
Tetracyn	60 mcg.	None
Ilotycin®	2 mcg.	None
Ilotycin	5 mcg.	None
Ilotycin	15 mcg.	None
Mysteclin®	20 mcg.	Very slight (0.5 mms.)
Sulfathiazole	5 mcg.	None
Gantrisin®	5 mcg.	None
Sulfadiazine	5 mcg.	None
Terfonyl®	5 mcg.	None

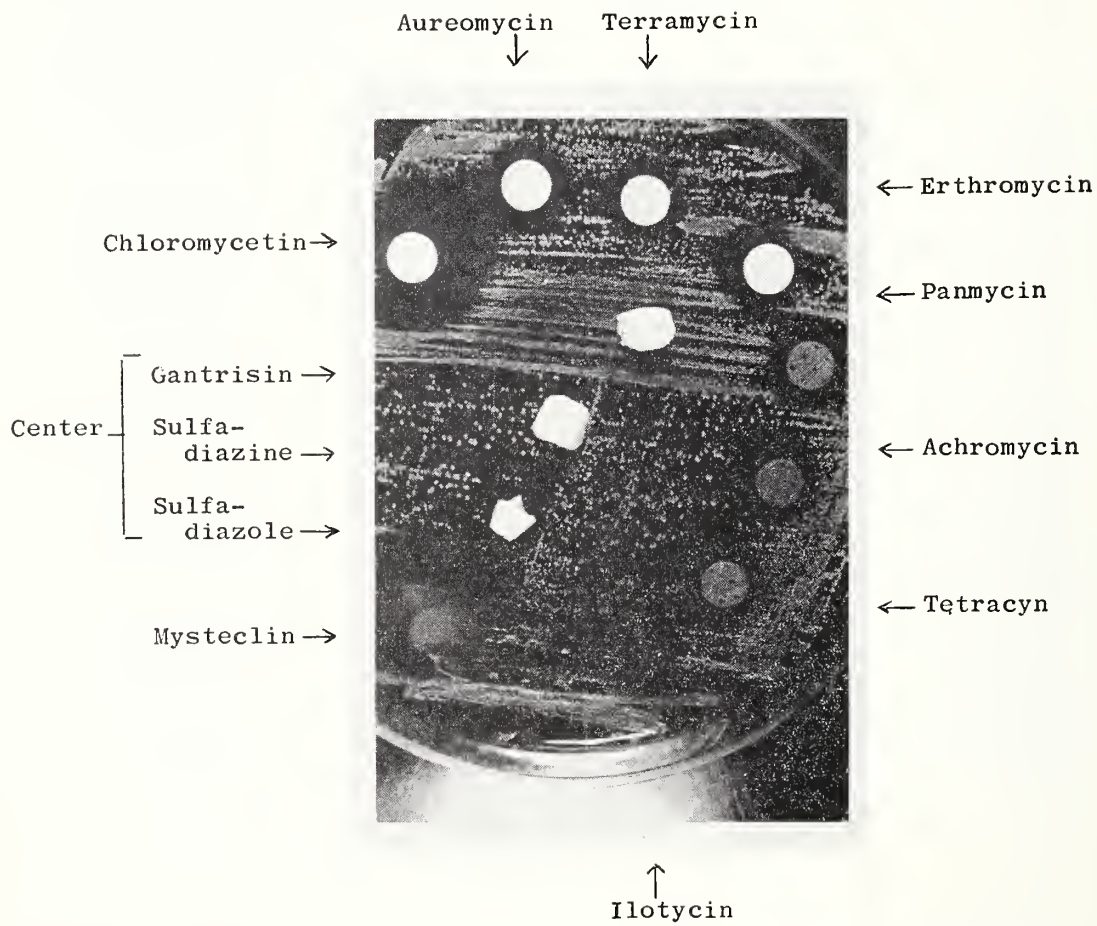


Plate 2. Disc of Chloromycetin and Mysteclin now show zone of clearing upon addition of isonicotinic acid hydrazide to culture plate.

around each disc of antibiotic placed on the culture plate. As the table indicates, a faint zone of clearing was observed around the disc of Chloromycetin® and Mysteclin® but this was very slight.

On the sixth day of the septic course and based upon our laboratory findings the patient was given Chloromycetin 1 Gm. intramuscularly every six hours and Mysteclin 0.5 Gm. orally every six hours. The clinical course remained unchanged and three days later the dose of Chloromycetin was increased to 6 Gm. daily. The clinical course remained unchanged and on the ninth day of the septic course the patient became delirious and moribund.

CHANGES IN BACTERIA INITIATED BY USE OF PARA-AMINOSALICYLIC ACID AND ISONICOTINIC ACID HYDRAZIDE

At this point we all felt that the organism isolated from the blood stream was too resistant to any of our antibiotics. We decided that the only course remaining open was to attempt alteration of the organism so that it would become sensitive to the antibiotics available to us.

Since we knew that the effect of streptomycin on the tubercle bacilli is enhanced by the use of isonicotinic acid hydrazide and para-aminosalicylic acid we decided to try similar measures here, hoping to alter the organisms somehow in order to render them less resistant to the antibiotics.

On the fourteenth day of the septic course the patient was placed on the following therapeutic regime:

1. Chloromycetin 1 Gm. every four hours intramuscularly.
2. Mysteclin 500 mgms. every four hours orally.
3. Isonicotinic acid hydrazide 150 mgms. every 12 hours orally.
4. Para-aminosalicilic acid 2 Gm. every six hours orally.

Simultaneously with the foregoing therapy the patient was given 4 pints of whole blood which had been exposed to ultra violet rays.

A tremendous clinical improvement was noted just twenty-four hours after the introduction of INH® and PAS. The patient became alert and

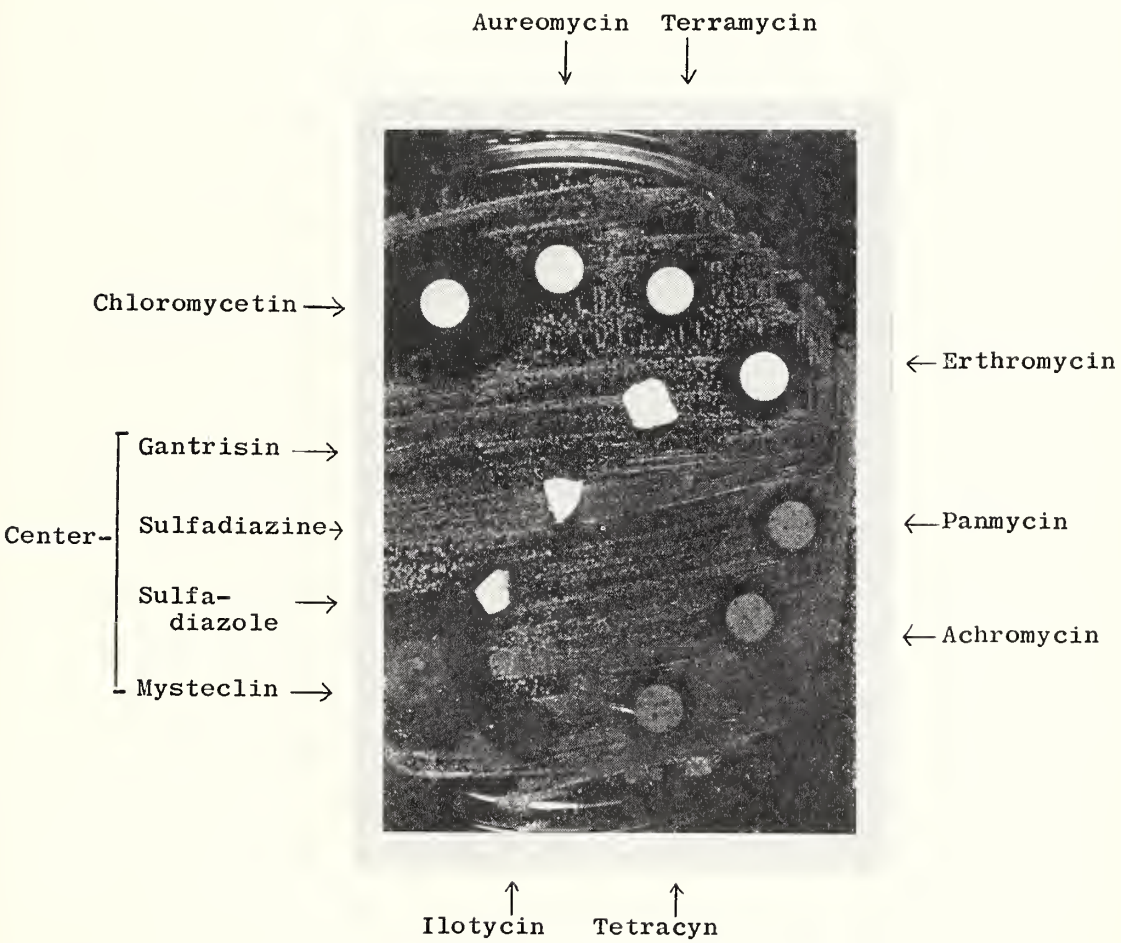


Plate 3. Discs of Chloromycetin and Mysteclin now show zones of clearing upon addition of para-aminosalicylic acid to culture plate.

cooperative. Within five days the temperature had returned to normal.

A blood culture taken three days after the onset of therapy with INH and PAS again showed Staphylococcus hemolyticus but to our amazement the organisms appeared to be normal in size and staining characteristics. Now there was no tendency to stain in a gram-negative fashion.

Five days after the introduction of INH and PAS the blood culture was negative and all subsequent blood cultures remained negative for the duration of the hospital stay. The patient was discharged one month later with no recurrence of positive blood cultures.

Our next problem was to determine which of the three new therapeutic agents, irradiated blood, INH, or PAS had changed the organisms sufficiently to render them sensitive to antibiotics. Thereupon we went back to our culture tube and prepared three new culture plates each containing the antibiotic discs listed in table 1. To one of these plates, we added irradiated whole blood; to the second culture plate we added INH; to the third culture plate we added PAS.

We soon discovered that our laboratory findings paralleled our clinical findings. The culture plate to which irradiated blood had been added showed no change in the resistance of the organisms to antibiotics. The plates to which we added INH and PAS showed that the organisms had become sensitive to the antibiotics, especially Chloromycetin and Mysteclin. These findings are summarized in table 2.

SUMMARY

In conclusion the following facts can be stated:

1. The bacteria isolated from the patient's blood stream was a strain of Staphylococcus hemolyticus which was slightly smaller in size and showed a tendency to stain in a gram-negative fashion.

2. This organism was completely resistant to all the antibiotics we tried except Chloromycetin

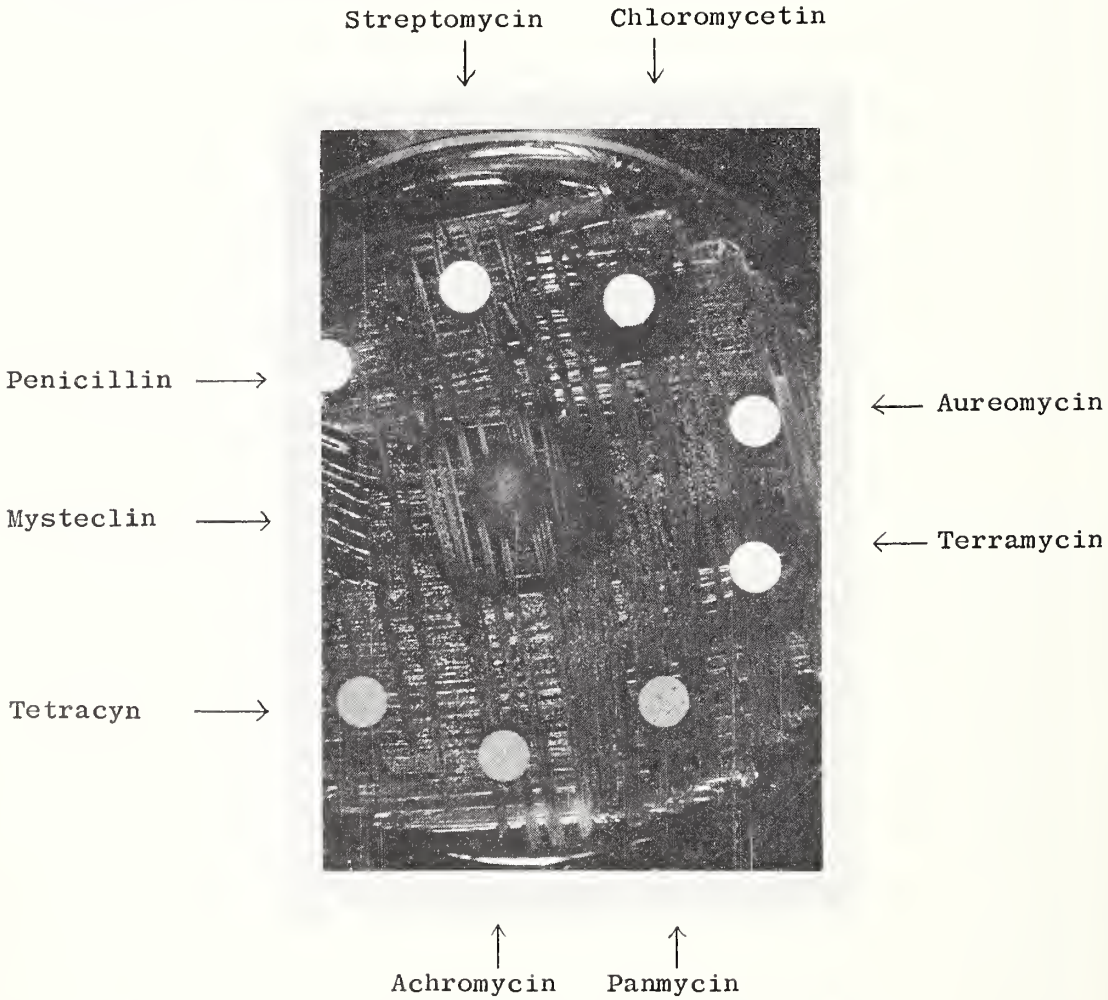


Plate 4. Much smaller areas of clearing are seen around discs of Chloromycetin and Mysteclin on culture plates not treated with isonicotinic acid hydrazide or para-aminosalicyiic acid.

TABLE 2

Antibiotic		Zone of Inhibition with Para-aminosalicylic acid		Zone of Inhibition with Isonicotinic Acid Hydrazide		Zone of Inhibition with Irradiated Blood
Penicillin	10 mcg.	Resistant	0 mm.	Resistant	0 mm.	Resistant 0 mm.
Streptomycin	100mcg.	Resistant	0 mm.	Resistant	0 mm.	Resistant 0 mm.
Chloromycetin	20 mcg.	Very sensitive	7.2 mm.	Very sensitive	7.8 mm.	Resistant 0.5 mm.
Aureomycin	20 mcg.	Moderately sensitive	2.3 mm.	Slightly sensitive	2.1 mm.	Resistant 0 mm.
Terramycin	100 mcg.	Slightly sensitive	1.8 mm.	Slightly sensitive	2.1 mm.	Resistant 0 mm.
Erythromycin	10 mcg.	Moderately sensitive	3.9 mm.	Moderately sensitive	3.3 mm.	Resistant 0 mm.
Panmycin	30 mcg.	Slightly sensitive	2.1 mm.	Slightly sensitive	2.4 mm.	Resistant 0 mm.
Achromycin	30 mcg.	Slightly sensitive	2.4 mm.	Slightly sensitive	2.4 mm.	Resistant 0 mm.
Tetracyn	30 mcg.	Slightly sensitive	2.4 mm.	Slightly sensitive	2.1 mm.	Resistant 0 mm.
Ilotycin	15 mcg.	Slightly sensitive	2.1 mm.	Slightly sensitive	2.1 mm.	Resistant 0 mm.
Mysteclin	30 mcg.	Very sensitive	7.1 mm.	Very sensitive	7.3 mm.	Resistant 0.5 mm.
Sulfadiazine	5 mcg.	Resistant	0 mm.	Resistant	0 mm.	Resistant 0 mm.
Sulfathiazole	5 mcg.	Resistant	0 mm.	Resistant	0 mm.	Resistant 0 mm.
Gantrisin		Resistant	0 mm.	Resistant	0 mm.	Resistant 0 mm.

and Mysteclin and the degree of sensitivity to these two antibiotics was very slight.

3. The addition of irradiated blood failed to alter the resistance of the organism to antibiotics.

4. INH and PAS definitely increased the sensitivity of the organism to antibiotics, especially to Chloromycetin and Mysteclin.

5. INH and PAS very probably changed the morphological characteristics of the organism so that it became normal in size and staining properties.

6. INH and PAS unquestionably saved the life of a moribund patient who was dying from septicemia.

7. We strongly feel that this approach to the problem of drug resistance merits complete investigation and further application.

Acknowledgment to John Apuzzio, A. B., Chief of Laboratory Technicians, Euclid Clinic Foundation.

Spasm of the Sphincter of Oddi

Spasm of the sphincter of Oddi has been demonstrated to be initiated by a host of agents and mechanisms. In man, spasm can be produced by painful distention of the common duct, by acid in the duodenum, by morphine injection, by parasympathomimetic agents such as pilocarpine, Mecholyl,® and Urecholine,® by the pain of venapunctures, and by emotional disturbances. Irritation of the colon of the dog often causes similar spasm.—Robert E. Delphia, M. D., Kansas City, Mo.: *J. Kansas M. Soc.*, 58:396, June 1957.

X-Rays and Leukemia

Irradiation has proved to be an important factor in leukemia, Dr. Paul Vlamynck of Berlin reported to the Berlin Radiologic Society (Jan. 29, 1957). A study of 269 cases of leukemia in children showed that 15.6 per cent of the mothers had had abdominal x-ray examinations during pregnancy. Radiologists get leukemia nine times as often, physicians 1.7 times, as the rest of the population.—*Antibiotic Medicine & Clinical Therapy*, April, 1957.

Mumps Involvement of the Central Nervous System

A unique feature of mumps is the observation of pleocytosis, as evidence of inflammation of the central nervous system, unaccompanied by any clinical symptoms of encephalitis or meningitis. Monod was the first to report this symptomless meningoencephalitis. He noted increased leukocyte content in the spinal fluid of six of eight patients with mumps.

In the literature of the last 50 years there have been a number of investigations of mumps with reports of the incidence of central nervous system involvement. The rather wide variation in the incidence of clinically apparent nervous system disease will be noted. While it is true that the factor of clinical judgment modifies data of this type, it is nevertheless rather hard to escape the conclusion that the virus may vary from one epidemic to the next in neurotropic quality. Henderson's report of 11 cases of clinically apparent central nervous system involvement in a total of 14 cases of mumps infection, was most striking.—Henry B. Bruyn, M. D., Harold M. Sexton, M. D., and Henry D. Brainerd, M. D., San Francisco: *California Med.*, 86:153, March 1957.

Action and Uses of Salicylates

Salicylates lower body temperature in the presence of fever, relieve pain and act as an excellent therapeutic test in acute rheumatic fever.

Caution must be used when the pleasant-tasting forms are put in homes where there are children. Over a hundred deaths occurred last year in children who had chewed and swallowed too many tablets.

Recently many combinations of salicylates and the adrenal steroids have appeared on the market. So far experience has shown that approximately 20 per cent of the patients will notice more benefit than they had from salicylates alone.—L. Maxwell Lockie, M. D., Buffalo: *Arizona Med.*, 14:143, March 1957.

A New Formula for Continuous Medication In the Asthmatic Patient

HERMANN BLATT, M. D.

FOR a long time iodides have been administered in the treatment of asthma because of their expectorant action. They render the bronchial mucus more watery and less tenacious and do not seem to affect the bronchial muscles.

Although iodine has been given in various forms for prolonged periods in the treatment of asthma and bronchiectasis, its effect on the thyroid is curious and even paradoxical.[7] Because it is used in the prevention and treatment of goiter, its goitrogenic action went unrecognized until 1952 when Bell observed goiter with and without myxedema in five patients who had taken iodine for two months to seven years.

Morgans and Trotter, Turner and Howard, Rubinstein and Oliner, and others have confirmed the fact that when the iodine intake is less than 0.1 mg. a day, the thyroid cannot make adequate quantities of the hormone and clinical symptoms of hypothyroidism develop; but, on the other hand, single doses of 5 mg. also block, temporarily at least, the formation of the thyroid hormone. The result is a rapid loss of iodine from the gland and the development of a goiter. These effects of prolonged iodine administration have occurred most infrequently in our series; nevertheless, it should be kept in mind, and patients should not be allowed to continue self-medication with iodine preparations whether they come from the physician's office or one of the many proprietary "asthmatic cures."

The author has had excellent therapeutic results in giving iodides to asthmatic patients. However, there always remains a group of patients who become iodine intolerant. They either find the metallic taste of iodides too obnoxious or develop other signs of iodism.

In addition to the iodine intolerant patient, one also encounters the patient who does not respond to epinephrine, ephedrine or the xanthine drugs.

In an effort to find a suitable substitute for such patients, we decided to study the effects of a tablet* composed of the following:

Each tablet contains:

Isopropylarterenol HCl	10 mg.	(in outer coat)
Phenylpropanolamine HCl	25mg.	inner core
Glyceryl Guaiacolate	100 mg.	inner core

This tablet is placed under the tongue until the outer coating is dissolved (sublingual absorption of the isopropylarterenol HCl), and the inner core then swallowed.

Submitted June 10, 1957.

*Bronkodyl,® generously supplied by The Columbus Pharmacal Company.

The Author

● Dr. Blatt, Cincinnati, is a member of the staff, Jewish Hospital; Contributing Editor, *The Review of Allergy and Applied Immunology.*

PHARMACOLOGICAL AND CLINICAL BASIS

1. **Isopropylarterenol HCl** is a valuable, rapid acting bronchodilator in the treatment of asthma. It is often effective in the patient who no longer responds to epinephrine or theophylline. It is usually administered as an aerosol inhalation or sublingually. Side reactions, sublingually, may occur in up to one third of the cases, principally a mild and fleeting tachycardia, seldom distressing enough to withhold the drug. This is less likely to occur than with epinephrine. Occasionally, precordial pain, headache, nausea and nervousness are encountered. Following sublingual administration, relief from paroxysms is generally felt in three to five minutes, and lasts from one to four hours.[1]

2. **Phenylpropanolamine HCl**, another sympathomimetic amine, acts similarly to ephedrine, and differs chemically from epinephrine only by lacking a methyl group on the amino nitrogen. The drug is a bronchodilator and vasoconstrictor, effective orally for controlling allergic symptoms in bronchial asthma and perennial hay fever. It has a more prolonged action than ephedrine and is less likely to cause central stimulation and produce anxiety complex.[2]

3. **Glyceryl Guaiacolate.** Only in the past few years has the problem of administering expectorant drugs been studied systematically in the laboratory and clinics. During an asthmatic attack, there is a spasm of the bronchial musculature with swelling of the mucous membranes and increased bronchial secretions, as well as the formation of mucosal plugs of a thick exudate. These plugs must be both liquified and expectorated if the patient is to have relief. Few of the conventional expectorants accomplish both.

Glyceryl Guaiacolate has been studied by various investigators [3,4,5] and found excellent for this purpose. Side effects are virtually absent, the patient expectorates easier, and there is less

useless coughing. It has been found superior to potassium iodide in producing relief and increasing vital capacity when used in conjunction with sympathomimetic agents in bronchial asthma.[5]

DESCRIPTION OF CLINICAL MATERIAL

One hundred and three patients suffering from allergic bronchial asthma of varying duration were selected at random for this study. Forty-eight were females and 55 were males. Their ages ranged from 10 to 85 years, although for the most part they were older patients with asthma of long standing in whom unfavorable effects might be more frequently encountered. Twenty per cent were known to be intolerant to iodides. No other medicine having a similar reaction was given during this course of study.

Prior to therapy, every patient had a complete allergic diagnostic study. This included a careful, detailed medical history, made complete by a thorough physical examination and such x-ray, electrocardiogram and other laboratory studies as seemed indicated. They were skin tested with all the pollens that are offenders in this area, some 20 of the common inhalants, some 114 foods eaten by people in Ohio, the common molds that cause asthma in Ohio, and some 20 of the more common bacteria used in culture for skin testing. Twenty-three of these patients had in addition, their white blood cells tested in vitro to over 125 bacterial strains for bacterial allergy. The Blatt-Nantz technique[6] was used for this procedure. On the basis of these tests, hyposensitization or desensitization was carried out. In this study, these investigations were the only other therapy given to the patient.

These asthmatics were divided into two groups. Forty-five patients were given the tablets four times a day for 12 days. The others took the medicine four times a day over periods of one to seven months. This was done to see if this drug would be well tolerated and effective with prolonged use.

CLINICAL RESPONSE

Clinical response was judged by the statements of the patients as to the amount of relief obtained. All patients studied were private ones of above average intelligence and had had enough experience with asthma to judge fairly accurately the response. They did not know that this drug was experimental. There was no discussion with the patient concerning its value or that it might be a "miracle drug." The patient merely received the tablets with instructions how to take them. Thus, there was the least amount of suggestion.

Excellent to satisfactory control of asthma was obtained in 91 (88 per cent) of these patients, using Bronkodyl® as the sole medication. Patients with histories of intolerance to iodides experienced no difficulty.

No patient in this series showed any permanent change in blood pressure. Neither were there ever any changes in the electrocardiogram tracings which were taken, when indicated, before, during and after treatment. None became allergic to the medication. Despite the fact that these were patients in whom unfavorable effects might be expected, side effects developed in less than 10 per cent of this series, occurring mostly among patients who were also intolerant to epinephrine. One patient developed a marked tachycardia and abdominal cramps, as is seen occasionally when administering ephedrine. The drug had to be discontinued in this case. Side effects manifested themselves as nervousness or a tachycardia of varying degrees of severity but without evidence of cardiac injury. One patient complained of insomnia, and another one of a metallic taste. In most instances, these symptoms were not sufficient to deter the patient from continuing to seek relief from the asthma by continuing the medication.

In two cases, the control of asthma was only partially successful. Both patients did not respond previously to a mixture of potassium iodide, caffeine and ephedrine liquid.

CONCLUSION

Bronkodyl is a good formula for continuous medication for the asthmatic, especially those who are intolerant of the iodides, or who do not respond to epinephrine or theophylline.

Patients intolerant to ephedrine or epinephrine may become shaky, nervous and develop a transient tachycardia. However, when Bronkodyl is continued, those patients with mild reactions of this kind, tend to become tolerant of it. Bronkodyl can be administered over weeks and months without any permanent side effects or loss in effectiveness.

Where iodine is not tolerated the substitution of Bronkodyl will correct the situation, or a little later the withdrawal of the iodides and the administration of thyroid extract daily will result in prompt disappearance of oncoming goiter. Here again treatment may be resumed, in our hands, with Bronkodyl.

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Primary Pleural Effusion*

JOHN A. PRIOR, M.D.

THE problem of differential diagnosis of a pleural effusion is often difficult. It is recognized that there are many diseases, each of which may be responsible for development of fluid in the pleural space. A partial list includes: tuberculosis, congestive failure, trauma, renal disease, pericarditis, fungus infections, infarct, collagen disease, primary pleural tumor or metastatic involvement of the pleura, from lung or elsewhere in the body.

In those who are past 40 years of age, the physician must be constantly on the alert for malignancy. In a large proportion of the patients, however, the causes cannot be readily ascertained, especially in young adults. Under these circumstances the fluid *must be considered tuberculous* and treated as such, at least until a definite diagnosis is established.

Primary pleural effusion occurs mainly in adolescence and young adult life. Apparently postponement of the primary tuberculous infection until after puberty predisposes to effusion, since pleural effusion is rare in childhood. The effusion is often formed as a part of the primary tuberculous infection during which the contents of a subpleural tubercle rupture onto the pleural surface which has become sensitized to tuberculoprotein. The pleura then responds by an outpouring of fluid. It is attended usually by mild or moderate pleuritic pain, fever, fatigue and weight loss. As the effusion increases in quantity separating the inflamed surfaces, there is relief of the pleuritic pain, which is frequently mistaken by the patient for recovery. Symptoms usually disappear within a few weeks and the fluid will absorb usually within 3 to 10 weeks, although some fibrous pleural thickening may be a permanent sequela.

STUDY OF FLUID VITAL

Careful study of the patient and his pleural fluid is vital. Often the effusion is not studied with sufficient zeal to obtain all the information possible. One cannot tell the propensity for coagulation simply by looking at the fluid and a congealed specimen is virtually worthless for satisfactory laboratory study. An *anticoagulant* such as heparin or citrate *must be added to every effusion* at the time of aspiration. Then, the specific gravity and protein content should be determined. Exudates have a specific gravity of 1.015 or above and the total protein will be 2.5 grams per 100 ml. or more.

The total cell count and differential in exudates will show usually many white blood cells (over 500 cells) with predominantly neutrophils (80 to 95 per cent) although tuberculous effusions will contain principally lymphocytes (often over 90 per cent). Careful study of the fluid for malignant cells by a pathologist trained in cytology is essential in every patient 40 years of age or more who develops an effusion. Although a bloody fluid may be the result of a traumatic thoracentesis, the presence of red blood cells is unusual in inflammatory effusions and suggests the possibility of cancer, either primary or metastatic.

Finally, meticulous bacterial study of every effusion is essential. The fluid must be cultured for routine bacteria and fungi, and special cultures and guinea pig inoculations for tubercle bacilli should be made. Even in a tuberculous pleural effusion a single culture of a small random specimen will show acid-fast bacilli in only a small proportion of patients. Using the largest volume of fluid possible, repeated studies by both culture and guinea pig inoculation will demonstrate tubercle bacilli in much higher percentage.

RELAPSE RATE HIGH

With relief of symptoms, absorption of the pleural fluid, and often virtually complete clearing of the chest roentgenogram, the patient believes he is well and should be allowed to return to work. However, the really treacherous portion of this condition lies in the months and years ahead. Various clinical studies show that from *25 to 65 per cent of all patients with a tuberculous pleural effusion will develop pulmonary and/or extrapulmonary tuberculosis within the next five years.* In those who develop parenchymal tuberculosis relatively few do so during the first six months. However, the great majority of those destined to relapse will have done so by the end of the first two years and relapse is rare after five years. The patient with minimal symptoms and a small amount of fluid that rapidly disappears is in just as much danger of later reactivation as his more unfortunate brother who is quite ill with an extensive and persistent effusion.

A tuberculous pleural effusion is almost always accompanied by a positive tuberculin skin

The Author

● Dr. Prior, Columbus, is professor of medicine, The Ohio State University College of Medicine.

*This is one of a series of articles on chest diseases sponsored by the Ohio Trudeau Society, medical section of the Ohio Tuberculosis and Health Association.

Submitted May 1, 1957.

reaction. In an effort to establish a diagnosis with the greatest certainty, biopsy of the pleura by needle or open thoracotomy is finding growing acceptance. However, unless a non-tuberculous etiology can be made definitely, every primary pleural effusion must be considered to be tuberculous and treated just as any other case of active tuberculosis providing that the tuberculin skin test is positive.

ANTI-TUBERCULOSIS THERAPY ESSENTIAL

Although we must grant that there are occasions when fluid under these circumstances is not tuberculous, this remains the only safe course to follow. All patients should be placed in a tuberculosis hospital for two purposes: rest and indoctrination into the nature and potentialities of his illness. Incidentally, almost all tuberculosis hospitals now accept this type of patient because it has been found to be financially advantageous as well as sound public health practice to hospitalize the patient with a tuberculous effusion to prevent the later prolonged and communicable illness.

Antituberculosis chemotherapy using either streptomycin 1.0 gram twice a week or isoniazid 5 to 7 mg. per kilogram per day, with sodium para-aminosalicylic acid 12 grams per day, should be administered and continued for at least one full year. After three months of rest the patient may be ambulatory but still should maintain increased rest. After six months he may return to light work and at the end of another three months he may resume his full activities. Evidence to date indicates that the relapse rate with this regimen will be quite low in contrast to the very high rates of reactivation reported in the past. It is the obligation of every physician to treat every pleural effusion as tuberculous with rest and chemotherapy unless other etiology is demonstrated.

You Never Can Tell

The old man sitting in the general store puffing on his pipe may get a cancer of the lip or he may live to a ripe old age and not get a cancer of the lip depending upon whether there are enough carcinogens in the tobacco he smokes, whether the pipe stem gets hot enough, whether perhaps he possesses a latent cancer virus, whether his ancestors gave him susceptibility or resistance, whether his hormones are in balance or imbalance, what he has eaten for the past 50 years, whether he possesses antibodies, whether his dentures cause chronic irritation, and whether or not he picked up a syphilitic scar in his younger days. Then, of course, there may he other factors which we still do not know. Only trouhle is, as far as our old man is concerned, there is no way to tell whether he will get it or not until the day he dies.—Freddy Homburger, M. D., Boston: *Northwest Medicine*, 56:807, July, 1957.

KEEPING UP WITH MEDICINE

• It appears that a diet rich in lipids has a significant enhancing effect upon the production of skin tumors. It has heen suggested that the fatty acid moiety may be responsible for this effect. This turns our thoughts to the more general importance of lipids for growth.

* * *

• It has been shown that a group of certain well defined substances containing fatty acid radicals have a greater co-carcinogenic effect than any hitherto know tumor promoters.

* * *

• In a young rat deficient in essential fatty acids, growth suddenly stops after six weeks probably because the necessary unsaturated fatty acids are not available in sufficient amounts for the formation of the phospholipids of new cell-membranes or the cystoskeleton.

* * *

• Anything that encourages the loss of water, such as a dry atmosphere, makes the dermatoses more evident. This may be why atopic eczema is usually worse in the wintertime in the overheated dry house.

* * *

• It would appear that the vitamin F activity of fatty acids is essential to the tissues of the brain.

* * *

• All the essential nutrients where biochemical roles have been studied have been found to be co-factors in essential enzyme systems.

* * *

• Rapeseed oil suppresses appetite and thereby lengthens the life span of rats 25 per cent over similar rats fed butter. This would suggest that this oil, and possibly certain other oils, might be useful in the treatment of obesity. If applicable to human beings this might lead to a more adequate way of treating obesity.

* * *

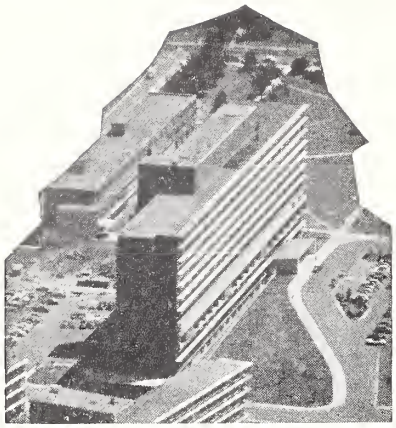
• The chyme lipids exist in an exceedingly dynamic state and out of this ever-changing mixture certain molecules, as yet undefined, pass across the intestinal mucosal border to be subjected in a new and probably different dynamic equilibrium within the mucosal cell.

* * *

• Cholesterol undergoing absorption becomes rapidly associated with the various cell components, mitochrondia, microsomes, etc., and at any given time a greater proportion is bound with these organettes than is dissolved in the fatty globules.

* * *

• It is the wide variability in fat content of the individual's body that leads to wide variations in protein, water, and electrolyte concentration in the whole organization—J.F.



A Case Record

From The University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Ralph J. Johansmann, M. D., President

Presented by Henry E. Wilson, M. D., and Emmerich von Haam, M. D. Edited by Dr. von Haam

PRESENTATION OF CASE

THIS 54 year old colored male was admitted to University Hospital with the chief complaint of chills and fever during the week before admission. The present illness began with episodes of chills and fever with sweating, anorexia and malaise. Three days later he developed occipital headache with persistent pain radiating down on both sides of his neck into the shoulder areas. He was unable to eat solid foods because of nausea, although he did not vomit, and he took only liquids during the last three days before admission. He had had no vomiting, hematemesis, diarrhea, constipation or weight loss.

He also complained of increased urinary frequency and nocturia, and he reportedly had two or three episodes of gross hematuria during the present illness; however, information on this point was rather vague. During the present illness he also complained of a slight nonproductive cough which aggravated the neck pain. He had had no recent sore throat.

The past history revealed that the patient had been unable to work for the past 10 years because of exertional dyspnea and minimal orthopnea. He never had had any chest pain. Increasing peripheral edema and marked varicosities of the lower extremities also contributed to his inability to work. He gave a history of rather severe chronic alcoholism for many years. A systems review revealed that the patient had had one episode of mild hematemesis two months before admission, which had not recurred. He also had complained of nocturia of 5 to 10 times for many years, with no change in the size of his stream. He had occasional two-pillow orthopnea and poor appetite.

PHYSICAL EXAMINATION

The patient was an obese orthopneic colored male. His blood pressure was 136/94, temperature 102° F., pulse 110. His skin was hot and dry. The sclerae and conjunctivae were normal. The pupils and external ocular muscles were normal, as were the fundi. The ears, nose and throat showed no abnormalities. The neck showed no masses although there was some diffuse tenderness over the left side where the left lobe of the thyroid was palpable. There was also some tenderness in the region of the left sternoclavicular joint.

The lungs were clear to percussion and auscultation with equal bilateral expansion. The heart size was normal to percussion, had normal sinus rhythm; the sounds were of good quality and there were no murmurs.

The abdomen was distended but soft; no organs or masses were palpable. There was a sensation of fullness in the left upper quadrant. There was no mention of tenderness. On rectal examination the prostate was symmetrically slightly enlarged, not nodular and of normal consistency. The neurological findings were physiologic. Both legs showed varicosities. There was some costovertebral angle tenderness.

LABORATORY DATA

His urinalysis on the first day showed a turbid brown urine with a volume of 90 cc., a specific gravity of 1.010 and a protein content of 320 mg.; no sugar or acetone was present. The sediment was loaded with red blood cells and contained 10 to 12 white blood cells per high power field. Repeated urinalysis gave similar results. Culture of a 24-hour specimen and guinea pig inoculation for tuberculosis were negative. The hemoglobin was 14.2 Gm., white blood count 17,650 with 43 per cent segmented forms, 33 per cent nonsegmented, 24 per cent lymphocytes. His serology was negative for syphilis.

His blood culture grew a pneumococcus which was sensitive to almost all antibiotics. Nose and throat swab showed alpha streptococci present. His serum sodium was 135 mEq., potas-

Submitted June 26, 1957.

sium 4.3 mEq., chlorides 135 mEq.; the van den Bergh was .4 mg. direct, .6 mg. indirect; his thymol turbidity was 7.5 units; the inorganic phosphorus was 6.9 mg., the alkaline phosphatase 5 units, acid phosphatase 0; his blood urea nitrogen was 116 mg.; his blood sugar was 126 mg.

His electrocardiogram on two occasions during the first two days of hospitalization was normal.

ROENTGENOGRAPHIC EXAMINATION

Chest x-ray showed a linear density in the right base with some increase in the lung markings. The left sternoclavicular joint showed no abnormalities. Flat films of the abdomen showed no soft tissue or bony abnormalities. The kidneys were at least of normal size. There were multiple calcifications seen in the small pelvis but none of these appeared to be urinary calculi. Repeated chest x-ray on the third hospital day showed the transverse heart diameter to be increased 22 per cent and the findings were thought to be those of an acute myocardial insufficiency with some degree of pulmonary hyperemia and/or edema.

HOSPITAL COURSE

The patient remained dyspneic with a strong tendency toward orthopnea. The chest remained clear to auscultation. The temperature, which was 102°F. on admission, declined somewhat but remained about 101°F. on the second day. He was started on penicillin and Gantrisin® in the usual doses. His abdomen remained protuberant and tense. Residual urine was 20 cc. The urethra was patent to a No. 18 catheter; no obstruction or stricture was seen. The patient was digitalized and given regular diet.

On the fourth hospital day the patient began to bleed massively from his gastrointestinal tract and was started immediately on whole blood. The blood pressure fell to 70/42, pulse 112; his extremities were cold. There were a few fine basilar rales and tachycardia but no murmur. The deep tendon reflexes showed increased activity but were equal and symmetrical. The cranial nerves remained intact and the patient was oriented.

Further laboratory findings at this time showed a blood urea nitrogen of 230 mg., a blood sugar of 242 mg., and a CO_2 combining power of 27 vol. His cephalin flocculation was 1 plus; his serum sodium was 124 mEq., his serum potassium 5.7 mEq., and blood chlorides 93 mEq. The hemoglobin was 6.4 Gm. and the white blood count rose to 22,300; platelets 452,000; reticulocytes .6 per cent. Two blood cultures drawn at this time proved negative, but the patient had been on antibiotic therapy.

The patient's urinary output varied between 1440 and 2700 cc. His temperature varied between 102° and 99°F. The patient continued to bleed massively from his gastrointestinal tract and expired on the fourth hospital day in spite of the use of whole blood transfusions with Levophed.®

CLINICAL DISCUSSION

Dr. Henry E. Wilson: If we just jump to the end of the story here, it is pretty obvious that this man died of hemorrhage, and for want of something specific to lean on I am not going to make the diagnosis of any primary lesion in the gastrointestinal tract. You would expect that one should discuss an ulcer, tumor, intussusception, or a massive infarction as the cause of his massive bleeding. But there is nothing to go on. Let us review the case.

This 54 year old man comes in with a very short history of immediate complaints, which with the exception of the chills and fever make a pretty good story for uremia. His chills and fever were apparently of recent onset, and three days later he complained of occipital headache and a persistent pain in the neck. So we have to postulate an acute septic process the source of which we do not know, but which is characterized by headache, fever and chills, and this diagnosis has some support from a positive blood culture.

MENINGITIS?

Thinking in these terms, we certainly cannot pass up the possibility of a meningitis. Pushing that thought a little bit further, since we do not have an obvious source for his sepsis, no draining ears, nothing in the nasopharynx or chest, we must think about the possibility of a rather occult bacterial endocarditis.

Let us leave the matter stand for a moment and go on with the next paragraph. Apparently things had not been fine with him before and he had had 10 years of trouble. He had been unable to work for the past two years because of exertional dyspnea. One very common cause of exertional dyspnea is obesity. But we can't pass up his dyspnea on the basis of obesity or laziness and have to make a case here for some degree of pulmonary congestion or pulmonary pathology at the outset, going back for 10 years. He also had some peripheral edema and some varices of the lower extremities, and it is said that those also contributed to his inability to work. This is pretty hard to qualify without seeing the legs, but maybe they did.

Then there is this history of a rather marked alcoholism for many years. Maybe that is why he did not work. To make matters a little bit worse, we find that he had mild hematemesis two months before admission, and reaching for straws, one could consider the possibility of a chronic gastritis or esophageal varices as well as peptic ulcer and tumor, etc., and in addition the possibility that his bleeding was on the basis of uremia. Anyway, his hematemesis did not recur until this present admission.

Now we come down to this business of urinary tract trouble consisting of recent hematuria and nocturia for many years. One of the commonest

causes for nocturia is evening conviviality over the bottle. People who drink beer during the evening void a great deal during the night and this man was admittedly a chronic alcoholic. There is no complaint directly referable to any obstructive uropathy and nothing to support the suggestion of diabetes mellitus or diabetes insipidus.

His nocturnal polyuria might also suggest cardiac failure with passive congestion of his kidneys, and that ties in pretty well with the occasional two-pillow orthopnea. It says that his appetite was poor. The blood pressure was 136/94, and that is rather surprising since clinically he really should have been hypertensive.

The kidney disease which he obviously had, and the cardiac enlargement which we think he had, could be better explained by hypertension, but he did not have it. We have to decide therefore whether he had had hypertension which in the presence of his sepsis went into remission, which it may do, or whether he did not have hypertension at all. I decided to rule out a silent coronary and the lowering of the pressure on the basis of sepsis in spite of his diastolic pressure of 94 and believe that he was essentially normotensive.

THYROIDITIS?

Oddly enough, his optic fundi were normal, which is rather hard to explain on the basis of his blood chemistry. The tenderness in his thyroid region could suggest a possibility of thyroiditis coincident with the other evidences of sepsis. The sternoclavicular joint is an interesting site of arthritis, the commonest cause of which used to be acute gonorrhea, but any other acute pyogenic infection may cause sternoclavicular arthritis, and we have seen it also occasionally in tuberculosis. That also could be tied together with his septicemia.

Although the lungs and the heart were negative on physical examination, the x-ray examination considered the heart enlarged and the lungs at least congested. The abdomen although distended was not tender and that sort of rules out fulminating peritonitis. The costovertebral angle tenderness is the first hint of some inflammatory disease of the kidneys. He had a low specific gravity of 1.010, turbid urine, and certainly microscopic and perhaps gross, hematuria. His first hemoglobin determination was probably high due to dehydration, while the second proved his anemia. He also had a leukocytosis and a positive blood culture. Since it was a pneumococcus it was probably not a contamination. We might wonder why he had a pneumococcus in his blood stream when he had alpha streptococci in his nose and throat culture.

His electrolytes were not remarkable and his van den Bergh was all right. If we are postulating liver disease in connection with his alcoholism and his hematemesis some time ago, the van den Bergh certainly will rule out serious cirrhosis. His blood urea nitrogen was 116, and I rather think that one week of septicemia is too short a period for him to have developed such a high nitrogen retention. I think we have to postulate an antecedent renal disease prior to the onset of his acute septic process. His first blood sugar was normal and his repeat sugar probably was altered by intravenous glucose therapy.

The patient received antibiotics and bacteriostatic agents in the usual doses and his abdomen became tense. This makes you think that he might have developed an ileus. He was digitalized, and he was given a regular diet, which at least tells us that he was able to sit up and eat. It does not say that he ate it, but that is implied. It is always interesting to go into the room and see the patient lying there comatose with a full tray beside him. I am sure you have seen that.

INTESTINAL BLEEDING

On the fourth hospital day he started this massive gastrointestinal bleeding, which we are not going to attempt to explain, and he was given whole blood at once, of course. Most of the things that happened from here on I think are accountable on the basis of this gastrointestinal hemorrhage. His blood pressure fell and he apparently went into some degree of shock. His blood urea nitrogen rose sharply, doubtless the result of absorption of blood.

His hemoglobin fell, as you would expect, as the result of his massive bleeding, and he developed a leukocytosis with appreciable elevation in his blood platelets, which we see in uremic as well as in hemorrhagic states. His fluid output was pretty well maintained on subsequent days in spite of what we consider bad kidneys. We certainly cannot blame the rising azotemia on that basis. This man finally bled to death.

We have talked about his septic process and about his heart disease, which we have not explained very well. We certainly have no hypertension to explain his cardiac enlargement, and if he is not hypertensive we would like to find some valvular disease. There is nothing in the contour of the heart or in the heart sounds to suggest that he had valvular disease, and I am thinking of course of old rheumatic disease which we commonly see in people at 54 years of age. He had diffuse cardiac enlargement.

Five to 10 years ago when somebody discovered myocardial failure we thought it was obligatory to diagnose his heart disease. It had to be luetic, rheumatic, arteriosclerotic, hypertensive, or something. We have come to realize in the past few years that you often cannot do that. There is much more viral myocarditis than we ever suspected, and there is much more toxic myocarditis with cardiac enlargement than we ever suspected. Probably 10 years from now we will have a great many more specific etiologies for

heart failure than we have today. I still fall back on toxic myocarditis as reason for his cardiac enlargement and I don't think that I can go much further here. I think that this man had some degree of heart failure in preceding years.

Now it is pretty obvious too that he had some renal disease. He had an elevated blood urea nitrogen which got worse in spite of a pretty good renal output, and he had renal bleeding from time to time and, finally, massive bleeding. A tumor of the kidney does not account very well for his renal failure because tumors usually are not bilateral. It is inviting to think of polycystic kidneys when one sees intermittent bleeding, but we would like to see hypertension with polycystic and large palpable kidneys. The radiologist won't say that these kidneys were not large but only that they were not small. I don't think polycystic kidney is the answer.

THE KIDNEY?

Can we explain it on the basis of inflammatory renal disease? We have two conditions that are very difficult to choose between. One is chronic recurrent pyelonephritis and the other chronic or subacute glomerulonephritis, and if the process is very chronic it may be very difficult to differentiate between the two even on the basis of the most exacting tests of renal function, none of which were performed on our patient. In either one of these types of chronic renal disease I would expect to see somewhat shrunken kidneys and they don't look to be very shrunken on the x-ray film.

Then we have to consider amyloidosis with or without myeloma. Whenever you see nitrogen retention with proteinuria in the absence of hypertension you should always think of myeloma. However, in this case I would expect a higher degree of anemia than this patient had who came in with a hemoglobin of 14.2 grams.

So we have to choose I think between chronic renal disease, chronic pyelo, polycystic kidney and superimposed upon that the possibility of sepsis caused by a bacterial endocarditis with multiple focal emboli. I believe that this man did have some chronic renal disease but that his recent exacerbations were based upon diffuse focal embolic bacterial pyelonephritis. Now if anybody would like to suggest syphilis or tuberculosis, we will have to bring that too into our differental diagnosis. We have not accounted, as I said at the outset, for his gastrointestinal bleeding. He could have an ulcer or a cancer, but in the absence of further specific evidence I am going to stick with gastric bleeding on the basis of uremia and focal embolization.

GENERAL CLINICAL DISCUSSION

QUESTION: Does bacterial endocarditis have to occur in a previously diseased heart valve?

DR. WILSON: It is a common experience to have acute bacterial endocarditis develop on a valve which exhibited no murmurs and no evidences of valvular failure prior to the acute illness.

QUESTION: How often do you find a person with a blood urea nitrogen of 160 and chronic renal disease who will not have hypertension and anemia?

DR. WILSON: It isn't very common, a point which I tried to make. I don't know how long chronic renal disease can go on without hypertension, but I do know that we do see appreciable degrees of renal failure in patients who are not hypertensive. Similarly, it is uncommon to see chronic renal disease without some degree of anemia, but I have seen it occur.

QUESTION: What do you think was the source of his pneumococcal septicemia?

DR. WILSON: Usually we don't find it. We assume that it is somewhere in the nasopharynx. The common place in the old days was chronic middle ear infection.

QUESTION: How often have you seen a patient with azotemia bleed to death due to azotemia alone?

DR. WILSON: I am sure it is very uncommon. There is no doubt though that the patient bled to death, but can we put it on a uremic basis alone? Clinicians are more impressed with uremic hemorrhage than the pathologists.

CLINICAL DIAGNOSIS

1. Acute septicemia, pneumococcal, of unknown origin.
2. Possible acute bacterial endocarditis.
3. Antecedent chronic renal disease.
4. Superimposed embolic nephritis.
5. Fatal uremic hemorrhage from gastrointestinal tract.
6. Uremia.

PATHOLOGICAL DIAGNOSIS

1. Subacute bacterial endocarditis of mitral valve.
2. Acute hemorrhagic nephritis.
3. Early cirrhosis of the liver.
4. Uremic colitis.
5. Septicemia.
6. Uremia.

PATHOLOGICAL DISCUSSION

DR. EMMERICH VON HAAM: This is a very interesting case and I would like to commend Dr. Wilson upon his very lucid discussion and his sharp diagnosis.

The body was that of an obese fellow weighing about 240 pounds. The lower extremities showed slight ankle edema and marked varicosities. The abdomen was protuberant and dark red blood seemed to ooze from the rectum. The peritoneal cavity was free of fluid. The heart was enlarged and weighed 650 grams. Both ven-

tricles appeared thickened and dilated. The mitral valve showed two large and rather firm vegetations measuring up to 1 cm. in length. The other valves appeared normal. The coronary vessels showed only minimal arteriosclerosis.

Both lungs appeared very voluminous and oozed large quantities of foamy hemorrhagic fluid. The liver was enlarged and finely granular. The stomach appeared dilated but did not contain any more blood. However, dark reddish and black material was found in the ileum and the colon. The wall of the latter was extremely hemorrhagic and contained several small diverticula.

The kidneys were enlarged and weighed between 240 and 270 grams. The surfaces were smooth but showed a brownish discoloration with darker brownish speckles all over the surface. The entire cortex showed similar speckling. The renal pelvis was not dilated. The lower urinary pathways were not obstructed. Examination of the organs of the neck showed a normal thyroid and no lymph glands. Examination of the brain was not permitted, but the spinal fluid appeared clear.

MICROSCOPIC EXAMINATION

Sections through the mitral valve showed platelet and fibrin thrombi with leukocytes and numerous bacterial colonies upon a slightly thickened, fibrous valve. The heart muscle showed interstitial fibrosis with scattered lymphocytes. Sections from the lungs showed alveolar hemorrhage with edema and fibrinous exudate such as observed in uremia. The liver showed microscopically periportal round cell infiltration and increased fibrosis but no severe parenchymal damage. Sections through the gastrointestinal tract showed edema and mucosal hemorrhages with superficial necrosis as typical of uremic gastroenteritis. The changes were particularly severe in the colon.

The kidneys showed moderate chronic pyelonephritis as seen in many kidneys of older individuals. In addition severe and acute lesions were found involving all glomeruli. They were large with marked proliferation of the endothelial cells and mild leukocytic infiltration. The Bowman spaces were distended with hemorrhagic exudate and many blood cell casts filled the convoluted tubules. The interstitial tissue showed very little change and the vascular apparatus appeared normal. From this we made the diagnosis of acute hemorrhagic glomerulonephritis, a lesion which falls into the group of allergic toxic nephropathies.

In conclusion we can state that the patient died from a rather acute illness—a subacute bacterial endocarditis probably superimposed upon a rather mild and inactive rheumatic condition with diffuse hemorrhagic glomerulonephritis and uremia. His severe gastrointestinal bleeding was due to the uremia which was caused by his acute hemorrhagic nephritis—one of the less common forms of kidney lesions seen in septicemia.

GENERAL DISCUSSION

DR. WILSON: This of course comes as a complete surprise to me. It is in complete variance with what I expected to find in subacute or acute bacterial endocarditis. I thought he had antecedent renal disease and a superimposed focal embolic nephritis. Acute hemorrhagic nephritis is a different disease from what we were talking about. I am reasonably sure that it is uncommon in bacterial endocarditis or indeed in sepsis of any kind. It can produce profound renal failure and cause extensive renal bleeding.

QUESTION: Could the liver have contributed to any of the gastrointestinal hemorrhage?

DR. VON HAAM: I don't know. No esophageal varices were found.

QUESTION: What about the pain in his thyroid region?

DR. VON HAAM: The thyroid showed no significant changes.

DR. WILSON: I thought he had thyroiditis.

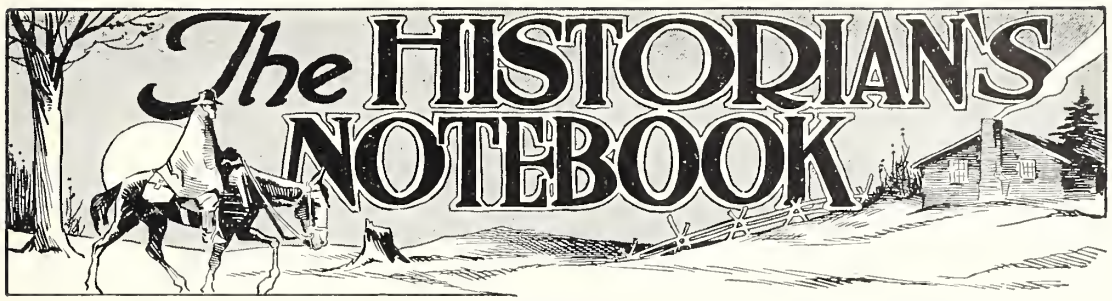
DR. VON HAAM: No, it must just have been a "pain in the neck."

Generalized Fungus Infections Assume Dangerous Stature

Generalized fungus infections, systemic moniliasis and disseminated candidiasis are synonymous terms which have appeared in the literature of the past few years. Evolving from a status heretofore considered rather benign and innocuous in nature, these infections have assumed a stature of a most dangerous and serious form necessitating an understanding on the part of the clinician as to their etiology, pathogenesis, prevention and treatment.—Walter Kohn, M. D., Baltimore: *Maryland State M. J.*, 6:254, May, 1957.

Efforts To Produce Experimental Arthritis Are Reported

Efforts to produce experimental arthritis by immunization of animals with joint tissues have been made in several laboratories. McKee and Swineford immunized guinea pigs and rats with homologous joint and kidney tissue combined with heat-killed beta-hemolytic streptococci. No precipitating antibodies or pathologic abnormalities in joint or other organs resulted. Glynn and Holborow were able to cause a synovitis in rabbits by immunizing them with chondroitin sulfate from human costal cartilage combined with live beta-hemolytic streptococci.—Cutting B. Favour, et al.: Arthritis Research. *New England J. Med.*, June 7, 1956.



Hospital Transports

With Special Reference to the Steamboat *Allen Collier* and the Cincinnati Branch of the U. S. Sanitary Commission

ROBERT H. PRESTON, M.D.

PART I

"BIG EVENT"

THE beginning of the Civil War caught both sides unprepared, despite the fact that its forthcoming was realized. The general public in the north looked upon the war as a "big event." It was felt that one big battle would be decisive and everyone wanted to be part of it. Enrollment into the service was for a mere three month period. Excitement ran high with emphasis on fancy uniforms and farewell parties. The Zouaves, for example, marched off to war in scarlet trousers, gaiter boots, buff leather leggings, a blue jacket trimmed with orange colored braid and a red cap with orange trimmings.

Emotion was high and excitement was general but no advanced preparation had been made and suddenly the wheels of war were put into motion. Men were called to arms; leaders found to drill and train the green recruits. Swift production of guns and ammunition was imperative. Means of transportation to move these men and supplies were needed. Small wonder that after the first battle it became apparent that nothing had been done for the Medical Division of the Army.

LACK OF ARMY GENERAL HOSPITALS

At the outbreak of the war there was not a *single* Army General Hospital. The staff consisted of the Surgeon General, 30 surgeons and 83 assistant surgeons. From this group three surgeons and 21 assistant surgeons resigned and entered the service of the Confederacy while three assistant surgeons were dismissed for disloyalty, bringing the grand figure to one Surgeon General, 27 surgeons and 59 assistant surgeons. Congress did not seem to be concerned over this problem since it increased the Medical Department by a mere 10 surgeons and 20 assistant surgeons in the first 12 months of the war. The total number of medical officers and contract surgeons used during the entire war was 12,343.

In May, 1861, an ambulance service was suggested to General Scott. He referred the proposal to Surgeon General Finley who did nothing about it. Four months later, in September 1861, the Surgeon General of Pennsylvania offered to furnish the Army of the Potomac an ambulance corps consisting of 45 ambulances, 15 transportation carts with animals and harness, two officers and 67 men. The chief surgeon refused because medical officers could not command line officers and he asked that it be referred to the Secretary of War. No more was heard of it. Another year passed; in August, 1862, the ambulance companies were being put into use in the Army of the Potomac. General Halleck disapproved of the recommendation of the Surgeon General that they be employed in all the armies on the ground as it would be "too expensive, cumbersome, and apt to lead to panic."

ORIGIN OF U. S. SANITARY COMMISSION

Organization and leadership was needed. June 13, 1861, Lincoln approved an order creating the United States Sanitary Commission. The Unitarian minister, Reverend Henry Bellows,

The Author

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Presented at the meeting of the Ohio Historical Society in Cleveland April, 1957.

was president and the famous landscape architect, Frederick Law Olmsted, was secretary.

The Sanitary Commission was the Red Cross of the Civil War. It helped with the medical, food and clothing supplies. It furnished nurses, cared for refugees and collected donations to be distributed to the Army. The western branch of the Sanitary Commission had exclusive direction for relief of the Army west of the Mississippi. In the first year it outfitted almost all of the hospital steamers and furnished medical supplies to Mississippi gunboats. It maintained agents and hospital stores at all important fronts in the Western Department. Numerous soldiers' homes were set up under its jurisdiction, each of which could boast of caring for 600 men a day. Women nurses were selected and assigned to duty by the Commission in the Western Department. Hospital transports were maintained and directed primarily by the Sanitary Commission.

BEGINNING OF THE TRANSPORT HOSPITAL BOATS

The earliest records of the transport hospitals occurred in the West. Little has been written about this phase of the war and yet it had tremendous influence on the lives of many soldiers. In February, 1862, Fort Donelson fell to the Union forces due to Commodore Foote's gunboats and Grant's encircling lines. Relief for the wounded men during the siege, and battle left much to be desired. Each regiment was accompanied by just one medical officer. As the regiment passed into battle he stayed with the men sharing their fortunes and their dangers. When severe injury occurred, surgery was done on the spot and under fire. The mobile and less serious cases were sent 200 to 300 yards to the rear of the fighting to the most advanced point of the ambulance train. This depot was placed so as to be removed from the immediate range of fire, usually in a ravine with an escape route chosen to wind through the hills, eliminating exposure to the enemy.

The ambulance carried the patients to a field hospital, located completely out of range of fire. There the inmates were allowed to remain four or five days until arrangements had been made for transportation elsewhere. The next move was by steamer down the Cumberland River to hospitals at Paducah, Mound City, Cincinnati, Louisville or St. Louis. The need for hospital steamers became apparent and was summarized by surgeon John H. Brinton, U. S. V., Medical Director Army of Tennessee, "The lack of such means of transportation was in many cases, the cause of great misery to our poor invalids and to the certain knowledge of the author, many lives were consequently sacrificed."

CINCINNATI'S CONTRIBUTION TO THE SANITARY COMMISSION

The Cincinnati branch of the United States Sanitary Commission realized the need for immediate help so it chartered the steamboat *Allen Collier*, a 133 ton stern-wheel steam vessel built in Cincinnati. The ship was stocked with hospital supplies, cots, bedding and equipped with surgeons and nurses. It hastened to Fort Donelson to aid the suffering. On arrival it was discovered that due to crowded conditions the wounded had not been taken from the fields. The only available space for the injured was two steamers assigned to the Army Medical Department, *The Fanny Bullitt* and *The City of Memphis*, that were without any hospital supplies or food. Nothing was available but corn meal. Wounded men lay side by side on hard floors without mattresses or blankets. There was an inadequacy of medical aid.

(Concluded in October Issue)

The Story Behind the Word

Some Interesting Origins of Medical Terms

Triceps—Literally means three headed and is derived from the Latin "tres," or three, and "caput," or head. The term is the name of a muscle in the arm which was formerly called the triceps brachii.

Unguent—This word comes from the Latin "unguentum" or ointment and comes from the Latin word "ungo" meaning, I besmear.

Ulna—This is the Latin word for elbow and is related to the Greek word "olene," meaning arm or elbow. Celsus was among the first to use the term anatomically in the first century. Its use in English began about 1500.

Umbilicus—This is the Latin term for the navel and is the diminutive of the word "umbo" which denoted the boss or protuberant part of a shield. The Latin term *umbilicus* is akin to the Greek word "omphalos" or navel. Both Pliny and Celsus used the term umbilicus in the first century. The term was also used by the ancients to designate either a raised or depressed spot in the middle of anything. Wharton in 1656 gave the first good description of the umbilical cord. The term *umbilical cord* came to be used in English in the eighteenth century; prior to that time it was called the navel-string.

Vertex—An anatomical term designating the top or crown of the head which in Latin means a whirlpool and is derived from the word "verto" meaning to turn. Crooke in 1615 wrote, "The Latins Call it Vertex, because in that place the haires runne round in a ring as waters doe in a whirle-poole."

Virulent—A term derived from the Latin word "virulentus" and literally meaning full of poison. The word is composed of the Latin word "virus" or poison, plus the suffix "lentus" denoting fullness, or proneness to.

—Harry Wain, M. D., Mansfield, Ohio.

Hospital Accreditation Commission . . .

Has Complied With Most of the Recommendations of the AMA Stover Committee Analysis Shows; Supplemental Comments by Dr. Babcock

THIS article, the second in a series, deals with the recommendations of the AMA Stover Commission after it had reviewed the functions of the Joint Commission on Accreditation of Hospitals and shows what action the Commission has taken to comply with the Stover Committee conclusions. It is an up-to-the-minute report on the situation.

Much of the material is taken from Bulletin No. 12 of the Commission. However, supplementary data and explanations were secured directly from Dr. Kenneth B. Babcock, Chicago, director of the Commission.

The conclusions of the Stover Committee appear here in boldface type, followed by the comments and actions of the Joint Commission, and Dr. Babcock's comments, in lightface type.

1. **Accreditation of hospitals should be continued.**

Agreement.

2. **The Joint Commission should maintain its present organizational representation.**

Agreement.

3. **The Board of Trustees should report annually to the House of Delegates on the activities of the Joint Commission.**

No action by Commission indicated.

COOPERATION VITAL

4. **Physicians should be on the administrative bodies of hospitals.**

Very close liaison between the medical staff and the governing board of a hospital must be maintained. The method used to accomplish this should be determined locally.

By way of explanation, the Commissioners think that the composition of the governing board of a hospital should be determined at the local level and that the Commission should not specifically state whether physicians should or should not be members. From its inception, the Commission through its publications has stated that in accredited hospitals close liaison between the medical staff and the governing board is essential. To assure good quality patient care, good working relationships are vital. However, the selection of the most effective way to accomplish this goal in the individual hospital can best be determined locally.

RECOMMENDATIONS OF JUNE 1953

Attention is called to the recommendations made in June, 1953, by the Joint Committee of the Boards of Trustees of the American Medical Association and the American Hospital Association on Hospital-Physician Relationships, as follows—

Editor's Note: At the 1957 Annual Meeting of the OSMA, the House of Delegates instructed *The Journal* to publish material on hospital accreditation. The first article of a series on this subject appeared in the August issue, explaining the principles underlying the work of the Accreditation Commission. This is the second article.

In subsequent articles *The Journal* will present suggestions and information from the Joint Commission on medical staff meetings, and medical records and will present answers by the Commission to many varied questions on the activities of the Commission, standards set by the Commission, hospital administrative problems, etc.

"The general purpose of hospitals and physicians is to aid each other in the delivery of the best possible medical care to patients. To attain such a purpose requires full cooperation among medical staffs, governing boards and administrative heads of hospitals. One important method of attaining this objective is that duly designated representatives of the medical staff shall have full and direct access to the governing board with due consideration to the position of the administrator as chief executive officer of the hospital. The various methods by which the medical staff may have access to the hospital governing board follow. These methods are not listed in the order of their desirability, and there may be other acceptable liaison plans developed depending upon local conditions.

"a. The executive committee of the medical staff and a committee of the governing board with the hospital administrator can serve as a joint committee.

"b. Representatives of the medical staff can serve as members of the medical staff committee of the governing board with the hospital administrator.

"c. Representatives elected by the medical staff can attend meetings of the hospital governing board.

"d. Members of the medical staff can be members of the hospital governing board."

The Standards for Hospital Accreditation state that the 'governing body . . . should . . . establish a formal means of liaison with the medical staff preferably by a joint conference committee' (a or b above); however any one or combination

of the above methods that prove effective are deemed acceptable.

G. P. SECTION

5. General practice sections in hospitals should be encouraged.

The present policy of the Commission with respect to general practice sections should be continued, including the point that the decision as to the establishment of a general practice department should be made by the local medical staff.

Dr. Babcock emphasizes that "the Joint Commission has always endorsed general practice sections or departments." He points to Bulletin No. 13 of the Commission from which the following is quoted:

"Division of the staff into services or departments to fulfill medical staff responsibilities promotes efficiency and is recommended in larger general hospitals. Functional Division of the medical staff into more than the minimal medical and surgical services is frequently desirable. It is necessary that each autonomous service or department be organized and function as a unit.

PRINCIPLES LISTED

"Since the General Practice Department is not a clinical entity, the responsibilities of this department are not those of a clinical service. Because misinterpretation of the Standards relating to general practice departments continues, the Commissioners of the Joint Commission on Accreditation of Hospitals wish to reaffirm their stand on this matter.

"a. The responsibilities of this department shall be limited to administration and education. It shall not be a clinical service and no patients shall be admitted to the department. If and when desirable, however, the department may be made responsible for conducting the outpatient clinic in whole or in part.

"b. Since the Department of General Practice will not have a separate service, the members of the General Practice Department shall have privileges in the clinical services of the other departments in accord with their experience and training, on recommendation of the Credentials Committee. In any service in which any general practitioner shall have privileges, he shall be subject to the rules of that service and subject to the jurisdiction of the chief of the clinical service involved.

"c. The medical staff should give to the General Practice Department such administrative responsibilities in the conduct of medical affairs as are desirable to meet the needs of the hospitals.

"d. The Joint Commission endorses and recommends that Departments of General Practice be established in hospitals where the size of the hospital and the educational facilities make such an organization possible and feasible.

"e. Any action to create a Department of General Practice should be initiated by the generalists on the staff of a given hospital.

"f. A General Practice Department should have fair and equitable representation in all staff activities of the hospital.

"g. A generalist should be granted hospital privileges according to his training, ability, and demonstrated competence.

"h. A well functioning General Practice Department in a hospital is considered an attribute by the Commission."

STAFF MEETINGS

6. Staff meetings required by the Joint Commission are acceptable, but attendance requirements should be set up locally and not by the Commission.

The Commission, meeting in December, 1956, modified rule concerning attendance at medical staff meetings. The new standard reads as follows:

"Active Staff attendance shall average at each meeting at least 50 per cent of the active staff who are not excused by the Executive Committee for just cause. Each active staff member shall attend 50 per cent of staff meetings unless excused by the Executive Committee for just cause."

(The old standard made at least 75 per cent attendance compulsory, unless excused for just cause.)

EXPLAINED IN BULLETIN

Bulletin No. 14, issued by the Joint Commission in March, 1957, made the following comments on the change in the standards pertaining to staff meeting attendance:

"The modification of this Standard was recommended by the Committee on Standards which was charged by the Board of Commissioners to consider the "Conclusion of the Stover Report." The Board of Commissioners voted to accept the recommendation of the Committee on Standards for the following reasons:

"1. A well functioning medical staff with good intercommunication is essential to insure quality medical care.

"2. The general staff meeting is an important tool both as an administrative and educational device to keep the staff as a whole informed of hospital activities and to insure continuity of good medical practice.

"3. It is essential that every hospital have rules and regulations pertaining to attendance at medical staff meetings. In order to make certain that these rules are adequate, the Commission should furnish a specific yardstick in the Standards.

SHOULD REVIEW SETUP

"Medical staffs and administrators should realize that this new modified Standard supersedes,

as of publication in this Bulletin, the former 75 per cent attendance requirement. The different types of staff meetings or categories to be employed as explained in prior Bulletin No. 9 should be reviewed thoroughly. The surveyors of the Joint Commission have been instructed to look carefully at the performance of medical staffs as regards review of work performed in the hospital."

7. **The Joint Commission should not concern itself with the number of hospital staffs to which a physician may belong.**

The Standards for Hospital Accreditation do not restrict multiple staff appointments.

8. **The Joint Commission is not and should not be punitive.**

Agreement.

APPEAL PROVIDED

9. **The Joint Commission should publicize the method of appeal to hospitals that fail to receive accreditation.**

In the event a hospital is not accredited following a survey, the process of appeal is explained in a letter notifying the hospital that it has not been accredited. The letter is sent to the administrator of the hospital, the chairman of the Board, and the chief of staff.

The original Bylaws of the Joint Commission on Accreditation of Hospitals in Article III, Section 8 provide for such hearings. A copy of the Bylaws was distributed with the first issue of the Bulletin of the Commission in November, 1952.

According to Dr. Babcock "there has never been one single hospital that has made a formal appeal to our Board of Commissioners concerning non-accreditation. Several hospitals have appealed for earlier surveys than the usual one year, due to extenuating circumstances, but none has ever appealed the actual non-accreditation."

REPORTS OF FINDINGS

10. **Reports on surveys should be sent to both administrator and chief of staff of hospitals.**

Copies of the covering letter and recommendations sent to the administrator following a survey are also sent to the chief or president of the medical staff and the president of the governing board.

11. **Surveyors should be directly employed and supervised by the Joint Commission.**

Dr. Babcock states that recommendation has been carried out to date by the American Medical Association and the American College of Physicians. They have given the Commission a direct grant in aid which is used by the Commission to employ surveyors. The other organizations constituting the Commission, for reasons of their own, have not been able to do this as yet, though they are cognizant of the Commission's desire to try to comply in whole with the Stover recommendation.

12. **Surveyors should work with both administrator and staff.**

Agreement. The recommendation is being carried out.

ORIENTATION PLAN

13. **New surveyors should receive better indoctrination.**

An orientation program for surveyors has been established to carry out this recommendation.

14. **Blue Cross and other associations should be requested not to suspend full benefits to non-accredited hospitals until those so requesting have been inspected.**

Pertains to individual Blue Cross Plans and cannot be acted upon by the Joint Commission. However, Dr. Babcock reports that his office has no knowledge of any Blue Cross Plan ever holding up fees to any hospital, dependent on its accreditation.

15. **The American Medical Association should conduct an educational campaign for doctors relative to the functions and operations of the Joint Commission.**

16. **The Committee also suggests that the American Medical Association and the American Hospital Association encourage educational meetings for hospital boards of trustees and administrators either on a state or national level to acquaint these bodies with the functions of accreditation.**

EDUCATION PROGRAM

The Commission has expressed itself in agreement with suggestions No. 15 and 16 and willing to support the AMA and others in accomplishing the objectives enumerated.

The resolution adopted by the House of Delegates of the OSMA suggests that information should be obtained on what measures are being taken to correct "certain unnecessary requirements that are enforced within the Commission's framework." Dr. Babcock states that he is unable to comment on this point unless "those unnecessary requirements are specifically mentioned."

Any member who desires to cite specific requirements which he believes to be unnecessary should do so in writing to the Columbus Office of the OSMA which in turn will communicate with Dr. Babcock, asking for comment and advice.

Industrial Health Program on Fluorides Is Scheduled

The Institute of Industrial Health at the College of Medicine of the University of Cincinnati announces a three-day Symposium on Fluorides to be presented December 9-11.

The symposium will be open to physicians and dentists in industry and public health and to other professional persons who are interested in the subject. The registration fee will be $50.

For further information and application blank write to Secretary, Institute of Industrial Health, Kettering Laboratory, Eden and Bethesda Avenues, Cincinnati 19, Ohio.

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Fall Postgraduate Courses . . .

District Organizations Arrange Some Excellent Programs Within Easy Reach of Physicians; Other Postgraduate Courses Scheduled

PHYSICIANS will have an opportunity again this fall to attend many district postgraduate programs and other short courses. Some of these programs are traditional and are well known for their excellence by doctors of respective areas. Others have been designed to fullfill particular needs as refresher courses.

The opportunity to meet with colleagues and exchange ideas is no small part of many of these meetings, as well as the scientific and clinical discussion of current topics. A glance at these programs will reveal an excellent array of talented and accomplished speakers.

Additional information on these and other programs will be published in subsequent issues of *The Journal*. Following are programs announced before this issue went to press:

September 6-7—Ohio Chapter, American College of Surgeons, Second Annual Meeting, Toledo.

September 18-19—Ohio Academy of General Practice, Seventh Annual Scientific Assembly, Columbus.

September 27-28—Course in Pulmonary Diseases, Ohio State University.

October 3—Eighth Councilor District Program, Portsmouth.

October 5—Columbus Academy of Medicine, Clinic Day.

October 9—Montgomery County Medical Society, Founders' Day, with Second District Physicians, Dayton.

October 23—Sixth Councilor District Postgraduate Day, Canton.

October 23—Northwestern Ohio Medical Association, Annual Meeting, Defiance.

October 28 - November 1—Institute of Industrial Health, University of Cincinnati, Course in Occupational Skin Problems.

* * *

Ohio Chapter, American College of Surgeons Schedules Program

Last year the Fellows of the American College of Surgeons from Ohio organized the Ohio Chapter, American College of Surgeons. This organization is holding its second annual meeting September 6-7 in Toledo.

The headquarters hotel is the Commodore Perry. The chairman of the Committee on Local Arrangements is Dr. W. W. Green, 1838 Parkwood Drive, Toledo. Guest speakers will include Dr. Frederick P. Coller, professor of surgery at the University of Michigan; Dr. Paul Hawley, director of the American College of Surgeons; Dr. George Thomas, professor of anesthesia at the University of Pittsburgh, and Dr. R. Arnold Griswold, chairman of the Committee on Trauma, University of Louisville.

President of the Ohio Chapter is Dr. Edwin H. Ellison, University Hospital, Columbus. With registration opening Thursday evening, the first program feature will be at 9:30 a. m. Friday, September 6. Last session closes at noon on Saturday.

* * *

Ohio Academy of General Practice Annual Assembly Scheduled in Columbus, September 18-19

The Ohio Academy of General Practice will hold its Seventh Annual Scientific Assembly in Columbus on Wednesday and Thursday, September 18 and 19. All scientific programs, including the exhibits, will be in the Veterans Memorial Building, 300 West Broad Street. Postgraduate credit for members of the American Academy of General Practice is 12 hours.

The program has been announced as follows:

WEDNESDAY, SEPTEMBER 18

(All time is Eastern Standard)

8:00 A. M.—Registration and Visit of Exhibits.
8:45 —Addresses of Welcome.
9:00 - 9:45—**Current Problems in the Treatment of Infection,** Dr. Morton Hamburger, Cincinnati.
9:45 - 10:30—**The Art of Treatment with Tranquilizing Drugs,** Dr. Frank J. Ayd, Jr., Baltimore, Md.
10:30 - 11:15—Visit to Exhibits.
11:15 - 12:00—**Rehabilitation of the Hemiplegic Patient,** Dr. Paul A. Nelson, Cleveland.
Lunch and Visit to Exhibits.
1:30 - 2:15 P. M.—**Cervical Biopsies in Office Practice,** Dr. Malcolm L. Barnes, and Dr. George S. Allen, Louisville, Ky.
2:15 - 3:00—Visit to Exhibits.
3:00 - 3:45—**The Allergic Patient, His Problems, Office Diagnosis and Treatment,** (Emphasis on Bronchial Asthma), Dr. Nathan E. Silbert, Lynn, Mass.
3:45 - 4:30—**Intra-Articular and Peri-Articular Injections with Hydrocortisone in the Office,** Dr. J. I. Kendrick, Cleveland.
Banquet—**Both Doctors and Patients Are Human Beings,** Dr. Edward H. Rynearson, Rochester, Minn.

THURSDAY, SEPTEMBER 19

8:00 A. M.—Registration and Visit to Exhibits.
9:00 - 9:45—**Athletic Injuries,** Dr. Richard Patton, Columbus.

(Continued on Next Page)

9:45 - 10:30—**The Irritable Child,** James L. Dennis, Oakland, Calif.

10:30 - 11:15—Visit to Exhibits.

11:15 - 12:00—**New Methods for the Treatment of the Arteriosclerotic Heart,** Dr. Walter L. George, Cleveland.

Lunch and Visit to Exhibits.

1:30 - 2:15 P. M.—**Gynecological Disease in Adolescents and Children,** Dr. Edward Allen, Chicago.

2:15 - 3:00—Visit to Exhibits.

3:00 - 3:45—**Cosmetic Dental Problems in the Growing Child,** Dr. John E. Aldrich (D. D. S.), Columbus.

3:45 - 4:30—**Behavior Problems in Adolescent Children,** Dr. Louis J. Wise, Cincinnati.

* * *

Course in Pulmonary Diseases At OSU, September 27-28

Five sponsoring organizations have joined forces to offer a postgraduate course in pulmonary diseases especially for general practitioners and approved for credit by the Ohio Academy of General Practice. The course is scheduled at Ohio State University in Columbus on Friday and Saturday, September 27 and 28.

Sponsors are the Ohio State University College of Medicine, the Ohio State Medical Association, Ohio Trudeau Society, American Trudeau Society, and the Ohio Tuberculosis and Health Association.

Reservation for the course, accompanied by a check for $25 should be sent to: Mr. Bernard Lachner, treasurer, c/o Ohio Tuberculosis Hospital, Columbus 10. Registration is limited to 150. Hotel reservations should be made with the hotel of choice. The Neil House and the Deshler-Hilton have reserved a limited number of rooms for those attending, up until September 5. (The football weekend makes this early reservation necessary.)

An additional attraction is the Ohio State-Texas Christian football game on Saturday afternoon, September 28.

The registration fee includes one ticket for the banquet on Friday evening. Extra tickets at $5 each may be secured for those who wish to bring their wives.

The course has been designed to provide the physician in general practice with current concepts of pulmonary disease, cardiac surgery, and carcinoma with emphasis on practical aspects of diagnosis and treatment.

The program will be held in the Ohio Union Theatre, Ohio State University, High Street at 13th Avenue. The banquet will be held in the Hall of Mirrors, Deshler-Hilton Hotel.

Five outstanding guest speakers will be present to participate in the program. They are Dr. Arthur M. Olsen, Mayo Foundation; Dr. John B. Hickman, Duke University; Dr. Oscar A. Sander, Marquette University; Dr. William M. Tuttle, Wayne University, and Dr. Oscar T. Clagett, Mayo Foundation.

Details about these and other speakers as well as subjects of discussion were published in the June issue of *The Journal*, page 692.

* * *

Eighth Councilor District Meeting Set for Marietta, October 3

Eighth Councilor District Fall Postgraduate Program will be held at the Washington County Country Club, Marietta, on Thursday, October 3.

An excellent scientific program will be presented in the early afternoon with a team from the Cleveland Clinic participating.

A golf tournament has been arranged in the morning for those who wish to play. Picturesque Marietta, pioneer colony of early settlers in Ohio, has developed an equally attractive golf course, one of the finest in the state. Golfers will remember it for the Ohio Open Tournament last year. The club is located a mile out of Marietta on Route 7.

Buffet luncheon is available at the club for those who wish it.

The program will include the following speakers and subjects:

Dr. George Crile, Jr., well-known for his exhaustive studies and work especially at the Cleveland Clinic in connection with cancer, will speak on the subject, "Cancer, with Special Reference to the Thyroid and Breast."

Dr. A. W. Humphries, member of the staff for vascular surgery, Cleveland Clinic Foundation and Frank E. Bunts Institute, will speak on the subject, "Present-Day Status of Arterial Grafting."

Dr. Harriet Dustin, diplomate in internal medicine and clinical investigator at Cleveland Clinic, will talk on the topic, "Surgically Correctible Forms of Hypertension."

After the program a cocktail period will be followed by dinner and a program of entertainment. Reservation blanks are being sent with notice of the program to physicians of the Eighth District. Others who wish to attend are invited to make reservations with Dr. Deane Northrup, 328 Third Street, Marietta. Dr. Northrup is President of the Washington County Medical Society, host organization for the occasion.

Wives of physicians are invited. Arrangements for entertaining the visiting ladies have been made by the Woman's Auxiliary to the Washington County Medical Society.

* * *

Columbus Academy To Present Clinic Day, October 5

The Columbus Academy of Medicine is sponsoring "Clinic Day" on Saturday, October 5, at the Veteran's Memorial Building, 300 West Broad Street, Columbus. All sessions will be in the Assembly Hall, first floor.

Five out-of-state guest speakers have re-

sponded to an invitation to participate in the program. Their names, with the subjects to be discussed, are shown in the accompanying program.

Parking space is available immediately adjacent to the building. Pre-registration is essential by October 2 and may be made by contacting Dr. Jack Taylor, in care of the Columbus Academy of Medicine office, 79 E. State Street, Columbus 15, Ohio. Registration is $5 per person which includes luncheon. Emergency telephone calls at the meeting will be through CA 4-6116.

General chairman for the program will be Dr. Robert M. Zollinger, chief of the Department of Surgery, OSU. Four and one-fourth hours credit has been approved for its members by the Ohio Academy of General Practice.

The program has been announced as follows:

MORNING PROGRAM

Moderator: Dr. Norman O. Rothermich, president of the Columbus Academy of Medicine.

9:00 - 9:45 a. m.—Registration and Coffee Hour.

9:45 - 10:10—**Diagnosis and Treatment of Gout and Gouty Arthritis,** Dr. John H. Talbott, professor of medicine, University of Buffalo.

10:10 - 10:35—**Problems in the Treatment of Biliary Tract Lesions,** Dr. Waltman Walters, professor of surgery, Mayo Foundation, Rochester, Minnesota.

10:35 - 11:00—**Gynechiatry,** Dr. William K. Keller, professor of psychiatry, University of Louisville.

11:00 - 11:30—**Present-Day Concepts of Diagnosis and Treatment of Carcinoma of the Prostate Gland,** Dr. Reed M. Nesbit, professor of urology, University of Michigan, Ann Arbor.

11:30—Luncheon

AFTERNOON PROGRAM

Moderator: Dr. Robert M. Inglis, Academy President-Elect

1:00 - 1:25 p. m.—**Current Problems of Infections in the Newborn Period,** Dr. Waldo E. Nelson, professor of pediatrics and medical director, Department of Pediatrics, Temple University, Philadelphia.

1:25 - 1:50—**The Role of the Obstetrician and Gynecologist in the Diagnosis and Treatment of Breast Disorders,** Dr. Paul Bowers, associate professor of obstetrics and gynecology, Jefferson Medical College, Philadelphia.

1:50 - 2:00—Intermission.

2:00 - 3:30—**Panel Discussion—What's New?** Moderator, Dr. Walters.

3:30—Adjournment.

* * *

Montgomery County Founders Day Will Be Second District Feature

Physicians of the Second District Medical Society are invited to the Eighth Annual Founders Day Meeting of the Montgomery County Medical Society to be held on Wednesday, October 9, in Dayton.

Although this is essentially a county program, plans have been made to hold the Annual Second District election in connection with the meeting.

Guest speaker at the Founders Day Observance will be Dr. Paul M. Zoll, of Harvard University. Dr. Zoll has done much of the pioneer work on cardiac resuscitation and on the use of external cardiac pacemakers and defibrillators.

He will conduct an afternoon clinic at Miami Valley Hospital. The evening session will be held at the Biltmore Hotel, Dayton. His topic will be, "Modern Concepts in Management of Cardiac Arrest and Use of Pacemakers in Stokes-Adams Syndrome."

Dr. R. Dean Dooley, President of the Montgomery County Medical Society and Councilor of the Second District, announced that honored guests of the Society will be Past-Presidents of the Montgomery County Medical Society and Presidents of the County Societies comprising the Second District.

* * *

Sixth District Postgraduate Day Canton, October 23, 1957

Stark County will be host in Canton, Wednesday, October 23, for the annual assembly. All meetings, with the exception of the morning and afternoon panels in obstetrics and gynecology will be held at the Onesto Hotel. The obstetrics and gynecology meetings will be held at the Y.M.C.A., a half block away, until 4 p. m. at which time the group will join in a large panel on "Adolescence" at the Onesto.

An excellent group of speakers from many sections of the United States has been obtained and topics will be of interest to all physicians.

The Woman's Auxiliary has also planned an interesting day including luncheon and a style show. The ladies will join their husbands at the pre-banquet reception and banquet following the afternoon sessions.

Concluding the day will be a talk by evening speaker, Dr. William Bennett Bean, professor of medicine at The University of Iowa. He will entertain with his satire on the present-day practice of medicine as only he can present it.

The following subjects and speakers have been arranged:

Are Lipoprotein Determinations Predictive of Coronary Disease?, Dr. John W. Gofman, Institute of Medical Physics, Belmont, California.

Abdominal Tumors of Childhood, Dr. Orvar Swenson, associate professor of surgery, Harvard, Boston, Massachusetts.

Panels in Obstetrics and Gynecology—Habitual Abortion, Dr. Carl T. Javert, director of obstetrics and gynecology, St. Lukes, New York City; **Abnormal Bleeding of the Last Trimester of Pregnancy,** Dr. Leon Israel, chief of gynecology, Graduate Hospital, University of Pennsylvania, Phila-

delphia, Pa.; **Management of Diabetes in Pregnancy**, Dr. William P. Given, assistant professor of obstetrics and gynecology, Cornell, New York City.

Panel on Coronary Disease—Dietary and Pharmaceutical Approach in Prevention and Treatment, (Moderator) Mr. William B. Bean, professor of medicine, University of Iowa; Dr. Gofman, Dr. Philip Tumulty, associate professor of medicine, Johns Hopkins, Baltimore, Maryland.

Fashions and Trends in Infant Nutrition, Dr. Paul György, professor of pediatrics, University of Pennsylvania, Philadelphia, Pa.

Panel—Management of Biliary Tract Diseases and Associated Conditions, (Moderator) Dr. Robert Zollinger, professor of surgery, Ohio State University; Dr. Cornelius Sedgwick, the Lahey Clinic, Boston, and Dr. Swenson.

Panel—Carcinoma of Endometrium, (Moderator) Dr. Javert, Dr. Israel, Dr. Given.

The Adolescent Clinic, Dr. J. R. Gallagher, physician-in-chief, Adolescent Clinic, Peter Bent Brigham, Boston, Mass.

Collagen Diseases, Dr. Tumulty.

Panel — Amenorrhoea, (Moderator) Dr. Israel, Dr. Javert, Dr. Given.

Epilepsy, Dr. Clark Randt, Director of Neurology, Western Reserve University, Cleveland.

Panel—Management of Upper Gastrointestinal Tract Bleeding, (Moderator) Dr. Zollinger; Dr. Bean; Dr. Stanley Hoerr, Cleveland Clinic; Dr. Sedgwick; Dr. Swenson, Dr. Tumulty.

Pathological Conference—Ovarian Tumors, Dr. Javert, Dr. Israel.

The Use of the Newer Antibiotics, Dr. Robert Mercer, head, Department of Pediatrics, Cleveland Clinic.

Panel—Treatment of Benign Diseases of the Colon, (Moderator) Dr. Zollinger, Dr. Hoerr, Dr. Sedgwick.

Medical and Surgical Treatment of Parkinson's Disease, Dr. Randt.

Newer Concepts Regarding Cancer, Dr. Donald Effler, chairman, Department of Thoracic Surgery, Cleveland Clinic.

Panel—Adolescence, (Moderator) Dr. Gallagher, Dr. Bean, Dr. Given, Dr. György, Dr. Tumulty, Dr. Randt.

* * *

Northwestern Ohio Medical Association To Meet in Defiance, October 23

The Northwestern Ohio Medical Association will hold its annual program in the auditorium of Defiance College, Defiance, on Wednesday, October 23. The program will begin at 9 o'clock and be completed about 4 p. m.

This organization is composed of physicians of the Third and Fourth Councilor Districts. Participating in the carrying out of this program will be Dr. James R. Jarvis, Van Wert, Councilor of the Third District, and Dr. Paul F. Orr, Perrysburg, Councilor of the Fourth District. Dr. F. A. McCammon, Van Wert, is president of the NOMA this year and is in charge of program planning.

The Ohio Academy of General Practice has approved the program for six Category I credits for its members.

The program has been announced as follows:

The Doctor as a Witness, Dr. Edward J. McCormick, Toledo, Past-President of both the Ohio State Medical Association and the American Medical Association.

Treatment of Peptic Ulcer, Dr. Edward A. Marshall, Cleveland.

Recent Advances in Pediatrics, Dr. Daniel V. Jones, Cincinnati.

Interviewing Techniques, Dr. Arik Brissender, Cincinnati.

Treatment of Obliterative Diseases of the Lower Extremities, Dr. John J. Cranley, Cincinnati.

Orinase in the Oral Treatment of Diabetics, Dr. Geo. J. Hamwi, Columbus.

* * *

Occupational Skin Problems To Be Subject in Cincinnati

The University of Cincinnati Institute of Industrial Health has announced a course in Occupational Skin Problems for physicians, October 28 - November 1 at the Kettering Laboratory in Cincinnati. The program is being presented by the Department of Preventive Medicine and Industrial Health of the University. Collaborating are the U. S. Public Health Service and the University's Department of Dermatology.

Details may be obtained by writing: The Secretary, Institute of Industrial Health, The Kettering Laboratory, Eden and Bethesda Aves, Cincinnati 19, Ohio.

American Medical Writers Association To Meet in St. Louis, Sept. 27-28

Physicians interested in developing or improving their medical writing technique are invited to attend the 14th annual meeting of the American Medical Writers' Association to be held at the Hotel Sheraton-Jefferson, St. Louis, September 27 and 28. This is an organization dedicated to improvement in the communications of medicine and allied sciences.

The meeting will be held in connection with the annual meeting of the Mississippi Valley Society, September 25-27.

At this meeting, Dr. Jonathan Forman, Editor of *The Journal*, will be honored with a Fellowship Certificate in the organization. Dr. Forman has been a member for several years and is chairman of the association's Advisory Committee.

Physicians interested in medical writing are invited to correspond with the organization's secretary, Dr. Harold Swanberg, 209-224 W. C. U. Building, Quincy, Illinois.

Influenza Situation . . .

Whether or Not New Type Virus Will Bring Epidemic Is Not Known Now; Plans Made by Authorities To Meet Major Problems Which Could Arise

WHETHER or not Asiatic influenza will become a major health problem in Ohio this Fall and Winter could not be determined by public and medical authorities as this issue of *The Journal*, went to press. However, plans to meet a possible epidemic were being developed. Here are some pertinent facts and developments to date:

A few cases of Asiatic influenza have occurred in Ohio. Public health officials and physicians have been asked to be on the alert for the spread of cases. Physicians have been urged to make use of the facilities of the Ohio Department of Health Laboratory in diagnosing suspected cases.

State and local public health departments, in cooperation with the medical profession, will carry on a public education program to keep Ohioans properly informed on developments and on ways and means of prevention and treatment.

COUNCIL AND DWORK TO CONFER

Dr. Ralph Dwork, director, Ohio Department of Health, and other department officials, and The Council of the Ohio State Medical Association will discuss the influenza situation at the regular meeting of The Council on the week-end of September 14-15.

Pharmaceutical houses which are manufacturing the new vaccine against the Asiatic flu have notified Dr. Dwork that some vaccine will be available through regular drug channels in Ohio in early September.

No plans are being considered for mass public vaccination programs, Dr. Dwork says. He states that when the vaccine is available, people should go to their own physician for vaccination. The function of the health departments will be to work with physicians on diagnostic procedures and to carry on a publicity campaign to urge people to be vaccinated.

NO REASON FOR ALARM NOW

Dr. Dwork says that while he believes public health officials and the medical profession should be on the alert and be ready to meet an epidemic —if any—he sees no reason at this time for the public to become over-anxious or panicky as the cases to date have been mild in character and have not been difficult to handle medically. Few deaths from the disease have been reported in the United States, and the number of cases with major complications also has been few.

AMA TAKES ACTION

Nationally, the American Medical Association and the U. S. Public Health Service are working closely on an influenza preparedness program which can be used in case a serious influenza outbreak does occur.

As to the question of vaccination, the Board of Trustees of the American Medical Association has voted to cooperate with the United States Public Health Service in providing the public with information as to the need of vaccination against Asiatic influenza, provided the vaccine is safe and effective and there is a need for widespread immunization.

The following statement of policy was issued by the USPHS.

"The Public Health Service, in cooperation with the medical profession, will stimulate and promote a nationwide voluntary program of vaccination against the prevalent strain of influenza. It will not, however, request Federal funds for the purchase or administration of vaccine—except for its own legal beneficiaries. The State and Territorial health officers and the American Medical Association have jointly assured the Surgeon General that community resources, both public and private, will be mobilized to provide vaccinations for persons who are unable to pay for such protection."

ACTION IN WASHINGTON

So the USPHS can be adequately prepared, President Eisenhower asked Congress for $500,000 to enable the service to prepare for any possible epidemic and for authority to transfer $2-million of health service funds for use in case of a serious outbreak. The $500,000, according to press clippings, is to be used for educational activities; additional investigating personnel; expansion of the output of materials used in laboratory detection work. The government does not plan to buy vaccine except for the armed forces. It does not plan to establish a vaccine allocation system; instead, favors distribution of the vaccine in the usual methods.

The AMA Board of Trustees has set up a special committee, headed by Dr. Harold C. Lueth, Evanston, Ill., who is chairman of the AMA civil defense committee. The committee plans to inform all physicians, through state and county medical societies, on how to deal with any Asiatic influenza epidemic; urge state and county medical societies to prepare and develop stand-by programs and plans to cope with any epidemic should it occur; formulate plans at the national level to utilize all medical personnel, regardless of type of practice, in time of an influenza emergency, and coordinate state and local pro-

grams with public health agencies and health departments.

HOME CARE WILL BE IMPORTANT

Dr. Lueth has pointed out that reports indicate that stricken patients soon become bed-ridden and great reliance therefore must, of necessity, be placed on home care because of the current high occupancy rate in civilian hospitals. Special problems will develop, he stated, if the disease occurs in camps and at large meetings or assemblies because usually there are insufficient accommodations for providing bed care for large numbers of patients who suddenly become ill.

SIX FIRMS MAKING VACCINE

USPHS Surgeon General Leroy E. Burney has announced that the six manufacturers licensed to produce influenza vaccine have set a production goal of at least 60-million cc. or 60-million doses by February 1. Doctor Burney said the manufacturers have reported that they expect to have about 8-million cc. available by mid-September, including about 4-million cc. ordered by the military.

The Asiatic influenza is caused by a new strain of influenza virus which caused widespread epidemics affecting millions of persons in the Far East last spring. The new vaccine is a monovalent or single strain type designed specifically to combat this Asiatic strain. Because this virus is a new strain, Dr. Burney said, people have built no natural immunity to it. Because of the nature of the disease—its swift onset and short duration—precise, up-to-the-minute reports on incidence are difficult to obtain, Dr. Burney said. Other respiratory infections will occur which are virtually indistinguishable from influenza except by laboratory tests.

SYMPTOMS LISTED

Cases of Asiatic influenza so far have been marked by temperatures of 102 to 104 degrees, headache, sore throat, cough and muscle aches. The fever lasts three to five days, followed by weakness for several more days. The attack rate in the Far East was approximately 20 per cent with a death rate of about two-tenths of one percent.

The USPHS says past experience has indicated that a single injection of the vaccine will be about 70 per cent effective. Protection develops in 10 to 14 days and lasts approximately one year, it reports.

SECONDARY CONDITIONS NEED WATCHING

As supplies become available to the public, the Public Health Service will recommend that particular consideration be given to the vaccination of those whose services are imperative for the care of the sick and those needed to maintain other essential functions, Burney said. He said the Public Health Service has been in touch with the manufacturers of antibiotics, such as penicillin, and has recommended that they increase their supplies for use in fighting secondary infections arising from a possible epidemic. The antibiotics can be used effectively to combat pneumonia or other diseases which may strike as an aftermath of influenza, although they have no value in fighting the influenza itself.

The licensed influenza vaccine manufacturers are: Eli Lilly and Company, Indianapolis, Indiana; Lederle Laboratories, New York, New York; Merck Sharp & Dohme, Inc., Philadelphia, Pennsylvania; National Drug Company, Philadelphia, Pennsylvania; Parke-Davis & Co., Detroit, Michigan; and Pitman-Moore Company, Indianapolis, Indiana.

Physicians Who Need Nurses Invited To Use OSNA Placement Service

Physicians who need office nurses are invited to contact the Ohio State Nurses' Association, Professional Counseling and Placement Service. This organization will refer qualified nurses where they are needed from all over the state, Miss Celia Cranz, R. N., executive secretary of the association, announced.

If the prospective nurse requests, her professional biography will be forwarded to the physician-employer for review. In performing this personnel employment service for the nurses, there is no charge either to the nurse or the employer.

Application may be made or further information obtained by writing: Professional Counseling and Placement Service, Ohio State Nurses Association, 904 East Broad Street, Columbus 5, Ohio.

New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since July 1, 1957. The list shows the County in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

CUYAHOGA COUNTY
- Frederick N. Dickman, Jr., Cleveland
- Edwin M. Goyette, Cleveland
- Melvin R. Krohn, Cleveland
- Charan S. Sandhu, Cleveland
- Albert F. Schoeck, Cleveland

GALLIA COUNTY
- Frank R. Ford, Gallipolis
- Daniel G. Lareau, Gallipolis
- Arthur K. Smith, Gallipolis

LAWRENCE COUNTY
- A. Burton Payne, Ironton

LORAIN COUNTY
- John R. Bay, Oberlin

LUCAS COUNTY
- John H. Coleman, Toledo
- Alan D. Dawson, Toledo
- Paul D. Millikin, Toledo
- R. J. Wasylyshyn, Toledo

MAHONING COUNTY
- Angelo W. Geordan, Youngstown
- Jack Schreiber, Canfield
- David Shapira, Youngstown

MONTGOMERY COUNTY
- Hobart E. Klaaren, Dayton
- Theodore A. Sills, Dayton
- Ralph T. Streeter, Dayton

PORTAGE COUNTY
- Nathan C. T. Chang, Windham

SCIOTO COUNTY
- Hans Rudolf Beutner, Portsmouth
- John Vincent Munro, Jr., Portsmouth

Occupational Health Programs . . .

Statement of Procedures and Principles To Govern In-Plant Medical Programs As Adopted by AMA House of Delegates at 1957 Meeting

GUIDES of procedure and a set of basic policies relating to occupational health programs were adopted by the House of Delegates of the American Medical Association at the 1957 AMA meeting.

These will be valuable to industries which have an in-plant medical-health program or which are contemplating the establishment of such a program. Also, they will be helpful to medical and other personnel engaged in such programs as well as to local medical societies in their dealings with industries on matters relating to industrial medical and health programs.

Believing that County Medical Societies in Ohio, and others, should have the guides and policies readily available for reference, *The Journal* is publishing herewith the report entitled, "Scope, Objectives, and Functions of Occupational Health Programs," as prepared by the AMA Council on Industrial Health, presented to the House of Delegates by the Board of Trustees, and adopted by the House of Delegates. Note that the report distinguishes clearly between in-plant programs and various plans for comprehensive medical care of the sick. Also, note the final paragraph which emphasizes the importance of consultation by management of the local medical society in the establishment or operation of the program.

TEXT OF STATEMENT

Introduction.—As used in this statement, the term "occupational health program" means a program provided by management to deal constructively with the health requirements of employees and employers in relationship to employment.

The term "occupational medicine" means that branch of medicine practiced by physicians in meeting medical problems and needs under occupational health programs.

Occupational health programs in the United States stem from the medical services established by some employers in the middle of the 19th century to meet the needs of their employees in locations where medical services were not satisfactory or readily available. Further impetus to their development was given by the enactment of laws in various states which obligated many employers to maintain safe and healthful work environments and to compensate employees for occupational disability or death.

Occupational Health Programs.— Although health maintenance is primarily the responsibility of the individual, an occupational health program represents management's recognition of its obligation to provide a safe work environment and its opportunity to promote better health among its employees. While circumstances may affect the extent of certain services which may enter into a comprehensive health program, a high quality of performance must be preserved at all times.

COOPERATION ESSENTIAL

Cooperation between physicians, nurses, industrial hygienists, technicians and other personnel of the occupational health program and management personnel responsible for the employment, safety and well-being of employees is essential. Occupational health personnel should cooperate also with private and official community agencies providing health, safety, employment and welfare services.

Through the years many forms of occupational health programs have been developed from which has emerged an acceptable basic pattern. Experience indicates that success can best be assured when:

THE PROGRAM

1. The program

(a) Observes the basic principle of service to the individual by a physician and conforms to medical customs in the community.

(b) Complies with existing laws.

(c) Emphasizes prevention and health maintenance.

(d) Utilizes community medical resources when adequate or when they can be developed reasonably.

2. The physicians participating in the program

(a) Maintain high standards of professional service and conduct for the benefit of employee and employer alike.

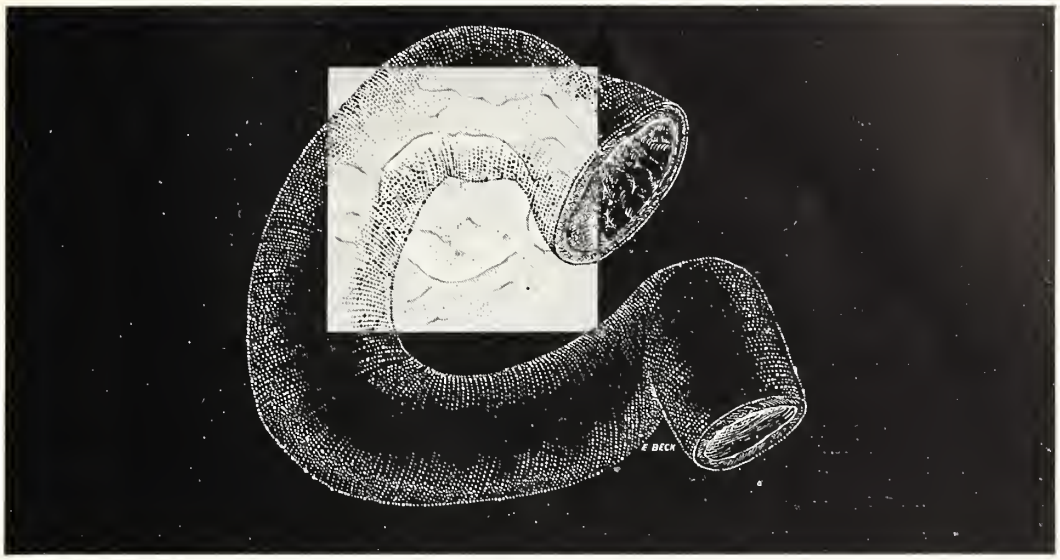
(b) Cooperate and maintain proper liaison with other physicians in the community and with the local medical society.

(c) Are engaged and compensated in accordance with the Principles of Medical Ethics of the American Medical Association.

(d) Do not use their occupational health affiliations as a means of gaining or enlarging a private practice among employees.

In recent years, with the recognition by employers and employees of the values attainable through occupational health programs which apply the advances in preventive medical and engineering knowledge, the earlier concept of curative occupational medicine has been broad-

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1. Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Am. J. M. Sc. *232*:156 (Aug.) 1956.
2. Sun, D. C. H., and Shay, H.: Arch. Int. Med. *97*:442 (April) 1956.
3. Rafsky, H. A.; Fein, H. D.; Breslaw, L., and Rafsky, J. C.: Gastroenterology *27*:21 (July) 1954.
4. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: Gastroenterology *25*:416 (Nov.) 1953.
5. Silver, H. M.; Pucci, H., and Almy, T. P.: New England J. Med. *252*:520 (March 31) 1955.

SEARLE

ened to include and emphasize prevention and health maintenance.

Although current programs reflect varying degrees of development, they all provide a common opportunity for employers, employees and physicians to carry on adult health programs which supplement other health services available in the community and which serve as effective components in community health.

HOW TO AVOID PROBLEMS

From time to time, problems arise out of a misunderstanding of the proper scope of occupational health programs as contrasted with medical programs for personal (non-occupational) illness of employees. It is, therefore, essential that employers, employees, and physicians recognize the fundamental distinction between these two types of programs.

In general, these two kinds of programs differ in objectives, methods of financing, amount and type of services provided, and in some cases, in the composition of the group covered. Although the same medical personnel may serve or administer both types of programs, certain activities of occupational health programs are not appropriate to, and cannot generally be performed successfully within the framework of, personal medical service programs. The occupational health programs must be oriented to the work environment and to the health of the employee in relation to his job. On the other hand, when service rendered by physicians under occupational health programs exceeds the limits described hereafter, the occupational health program becomes to that extent a medical program for personal illness and should be so recognized by all concerned.

PERSONAL ILLNESSES

Medical Programs for Personal (Non-occupational) Illness.—These programs owe their existence to certain factors and circumstances in the employer-employee relationship not directly related to occupational health considerations. A major objective of such programs is to distribute the cost of medical service so as to lighten the economic burden on the employee. Some programs include dependents and/or retired employees as well as the employed group. They are usually designed to provide medical, surgical, and hospital care. The cost of such programs may be financed jointly or solely by management, unions, or the subscribers. Medical services may be provided by personal physicians, or by physicians in management or union health centers, or by other physicians upon referral. Such personal medical services may be diagnostic, therapeutic or rehabilitative, and may be limited or comprehensive in scope. These programs are separate and distinct from occupational health programs, the objectives, activities, facilities and personnel of which are described in the remainder of this statement.

THE OBJECTIVES

Objectives of Occupational Health Programs.—The objectives of an occupational health program are:

1. To protect individuals against health hazards in their work environment.

2. To insure and facilitate the placement and suitability of individuals according to their physical capacities and their emotional make-up in work which they can reasonably perform with an acceptable degree of efficiency and without endangering their own health and safety or that of their fellow employees, and

3. To encourage personal health maintenance.

The achievement of these objectives benefits both employers and employees in terms of improved employee health, morale, and productivity.

Activities to Attain Objectives.—In order to attain these objectives the following activities (and the maintenance of appropriate records) are essential:

1. **Supervision of the work environment from a health standpoint.** This requires periodic inspections by physicians of the entire premises used by employees, including provision for, and appropriate participation in, the procedures and tests required to detect and appraise health hazards. Such inspections and appraisals provide current information on health aspects of work conditions, processes and substances used. This information, including those relating to stress and mental health, will aid in evaluating any health hazards that may exist and in making appropriate recommendations for preventive or corrective measures.

EXAMINATION PRINCIPLES

2. **Health examinations.** Unrealistic and needlessly stringent standards of physical fitness defeat the purposes of health examinations and of maximum utilization of the available work force.

Health examinations should consist of:

(a) An initial examination to determine the health status of the individual in order to facilitate suitable placement in employment. This examination should include (1) his family and personal medical history; (2) his occupational history; (3) a physical examination, and (4) other procedures to help determine the individual's employability and his capacity for work.

(b) Subsequent examinations carried out at suitable intervals and designed to detect any sign or symptom of ill health related to employment conditions and to evaluate the health status of the individual in order to determine whether his health is compatible with his job assignment.

All examinations must be conducted by physicians with such assistance from ancillary personnel as may be required. Prior to each examination, the individual should be advised as



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to its constructive purpose and value. At the conclusion of an examination, the physician should discuss his findings meaningfully with the individual. When health defects are found, the physician should explain to the individual the importance of obtaining further medical attention, and encourage him to consult his personal physician.

GOOD RECORDS IMPORTANT

3. **Medical records.** The maintenance of accurate and complete medical records of every individual from the time of his first examination or treatment is a basic requirement. Except when otherwise required by law, the confidential character of these records, including the results of health examinations, must be rigidly observed by all members of the occupational health staff, and such records must remain in the exclusive custody and control of the medical personnel. The patient should be informed of all pertinent health findings except when such disclosures would have an adverse effect on his health and well-being. A private physician or other agency may be provided with a report of health findings when the patient so designates. Disclosure of health information should not be made without the approval of the patient except when essential to fulfill the legal obligations to the third party or to the public, and then, only to the extent necessary to fulfill such obligations.

4. **Medical diagnosis and treatment.** Every employee should be encouraged to have a personal physician.

(a) Diagnosis and therapy required by workmen's compensation laws for occupational injury or illness should be directed toward optimum rehabilitation of the employee. The right of the employee to select his attending physician should be maintained. The attending physician may be a member of the occupational health staff or any physician in the community willing and qualified to perform the essential services.

(b) Diagnosis and therapy in case of nonoccupational injury or illness is not a responsibility of an occupational health program, with the limited exceptions noted below.

EMERGENCIES

Emergency cases should be given the attention required to prevent loss of life or limb or to relieve suffering until the patient is placed under the care of a personal physician.

For minor disorders, first aid or palliative treatment may be given if the condition is one for which the individual would not reasonably be expected to seek the attention of a personal physician, or to enable the individual to complete his current work shift before consulting a personal physician.

In occupational health programs, requests for treatment of repetitive personal disorders should be discouraged, and such individuals should be referred to their personal physicians.

(c) The best interests of a patient are served by cooperation and communication between attending physicians and physicians in charge of occupational health programs. In this way, prompt restoration of employees to suitable employment can be assured.

5. **Health and safety education.** A high standard of occupational health cannot be achieved without familiarity with, and the observance of, fundamental health rules. The development of an understanding of these rules and the promotion of their observance is an essential task in which an occupational health staff can render very valuable assistance.

An occupational health program should promote the education of employees in matters of personal hygiene and health and encourage the use of safeguards provided to protect against any hazards to health which may be inherent in their jobs. The most favorable opportunities for carrying on health education and counseling will be afforded during visits to health facilities and through periodic inspections of the employee's place of work.

ALL MUST HELP

Health and safety education involves the cooperative efforts of health, safety, and operating personnel. Such education should include not only the encouragement of habits of cleanliness and orderliness but also instruction, in collaboration with the employee's immediate supervisor in safe work practices, in the use and maintenance of available personal protective clothing and equipment.

Experience has showed that health education is unlikely to be successful unless the employer demonstrates his sincere and continuing interest in the health of his employees. This entails participation by health personnel in health and safety meetings. Likewise, employees should be encouraged to participate in the planning and conduct of health education activities and to make full and effective use of occupational health services and facilities available to them.

An occupational health program, to be effective and acceptable to the employee, must be staffed by objective and competent personnel who create an atmosphere of warm, sincere, and positive personal helpfulness.

Personnel.—All phases of an occupational health program should be under medical supervision. This requires the appointment of the medical director, full or part-time, who is a qualified doctor of medicine. Training and/or experience in occupational medicine is desirable. The medical director should have a responsible role in the development and interpretation of medical policy. He should administer the health program and be directly responsible to a desig-

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nated official at the policy-making level of management. Additional physicians, as consultants or associates, may be required for an effective program. The duties of these physicians should be clearly defined by the medical director.

Qualified auxiliary personnel, selected and directed by the physician in charge, are essential to the proper functioning of an occupational health program. According to program needs, these may include nurses, industrial hygienists, first aid attendants, and laboratory and clerical personnel.

NURSING PERSONNEL

A nurse should be a graduate of an accredited school of nursing, registered and legally qualified to practice nursing where employed. Training and/or experience in occupational health is desirable. She should assist the physician in the supervision of the health of employees while at work and in their health education. Her professional duties and nursing procedures should be clearly defined in writing by the physician to whom she is responsible.

One or more qualified first aid attendants, known to all employees, should always be available during working hours. They should receive periodic refresher instruction and be provided with specific written instructions by the physician in charge.

THE FACILITIES NEEDED

Facilities.—The facilities of an occupational health program may be available at the place of employment or in the community. When provided on the employment premises, facilities should:

1. Be located in a quiet area, readily accessible to employees;
2. Be sufficiently spacious, well lighted, ventilated and heated;
3. Include waiting, consultation, examining and treatment rooms, and toilet facilities, to insure adequate privacy and comfort; and
4. Have appropriate medical and laboratory equipment.

It may also be desirable to provide a rest or recovery room, dressing rooms and facilities for laboratory and radiological examinations.

Conclusions.—Specific and detailed recommendations as to facilities, personnel and other aspects of individual occupational health programs obviously are beyond the scope of this statement. It is recommended that the local medical society be consulted to assure that a given program is in agreement with the objectives of this statement and with established community practices.

Ohio's first Controlled Driver-Training Range was opened in Columbus recently at the State Fair Grounds. Set up primarily for high school youngsters, the course was modeled after Detroit's "Off-Street Multiple Car Plan," which has been in operation since 1945.

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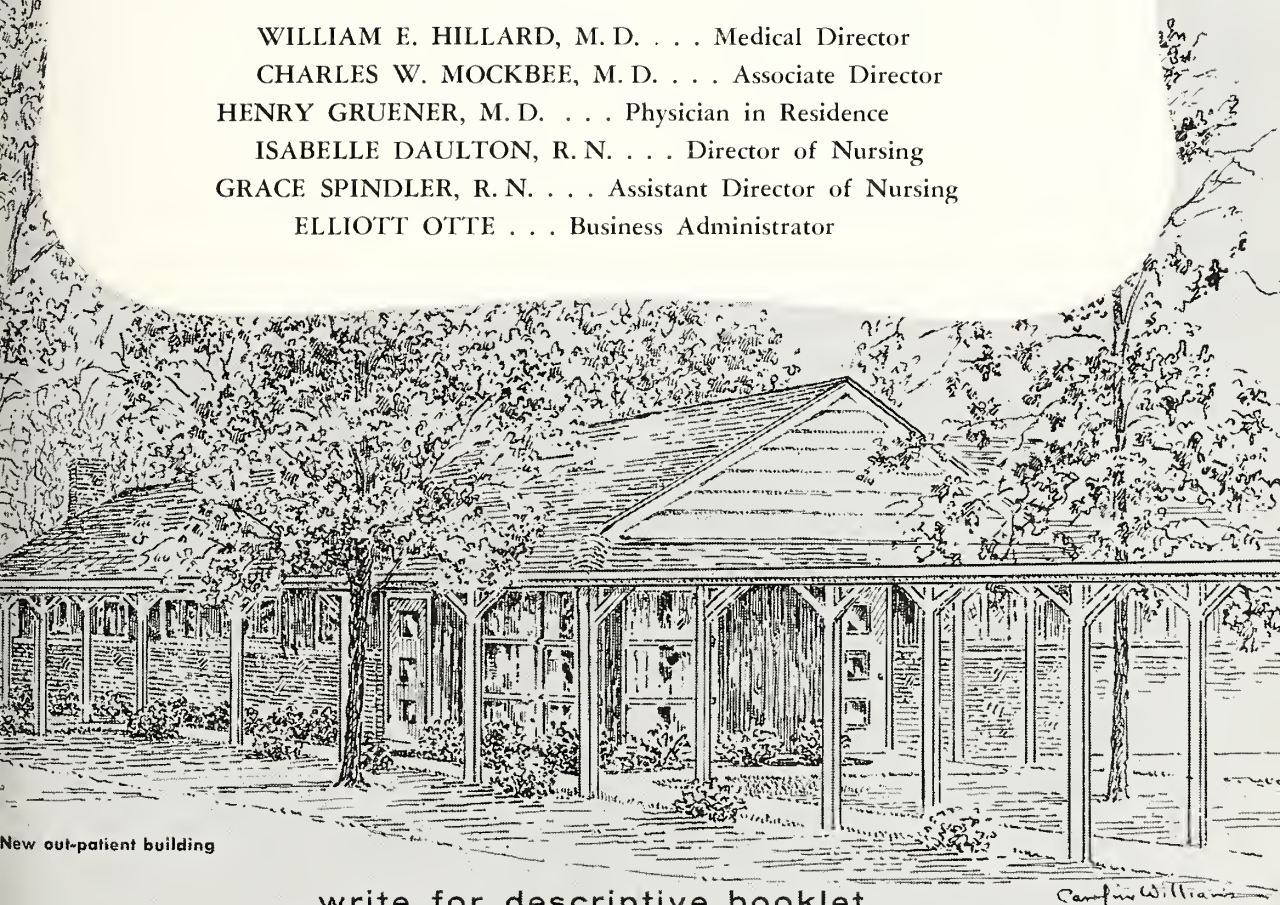
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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

WARNING TO DRUG FIRMS ON DISTRIBUTION OF FLU VACCINE

Reports have reached the OSMA Columbus Office that salesmen of some of the drug firms which are producing the new influenza vaccine are pressuring personnel directors or purchasing agents of large industries to order substantial quantities of the vaccine. This is quite disturbing to many of the physicians in charge of the medical services of industries. It should be disturbing to others, including the drug firms themselves, because this practice is sowing the seeds of possible rigid government control of the distribution of the vaccine—something which should be avoided if at all possible.

This situation has several bad aspects.

First, physicians are pretty well agreed that the administration of the vaccine is a function which should be performed, and can best be performed, by the personal physicians of employees —not by industrial physicians or government physicians, unless very unusual circumstances prevail. When an industry stocks up on vaccine, the natural ultimate step will be to have the plant's physicians vaccinate employees. This could create a breach between industrial physicians and physicians in private practice through no fault of either.

Second, and more important, if the supply of vaccine is going to be gobbled up by big industries or by other preferred groups, a real problem of mal-distribution will occur. What about the little fellows—employees of small plants and offices, the self-employed, students, etc.? Will their personal physicians who will be expected to vaccinate them, be able to get vaccine through regular commercial channels or will they be short-changed because of the filling of the big orders placed by industries and other priority groups?

The drug firms should give this matter serious thought. They should discontinue solicitation of orders on a big scale at this time. Continuation of the practice could easily result in the clamping on of government controls on distribution of the vaccine which, in our opinion, they do not want—in fact, no one wants except perhaps those few who would like to see government control and supervise everything.

PRECEPTORSHIP PROGRAM IS OUTSTANDING SUCCESS

Reports of the June preceptorship program carried out by the Committee on Rural Health, OSMA, clearly indicate that this first such venture in Ohio was an outstanding success.

While it will be no news to the rural practitioner, worth repeating here is a statement by one of the 15 student preceptees, who told a Cincinnati newspaper, "Everyone was impressed with the up-to-date medicine these doctors practice," and "they keep themselves abreast of the newest developments." The newspaper headlined the story: "UC Medical Students Thrilled over Life with Rural Doctors."

Purpose of the program was to teach students the medical way of life and to stimulate their interest in practicing medicine in a rural area. Comments from students, doctors and from residents of communities where the program was carried out show without exception that preceptorship is a worthwhile undertaking.

CONFERENCE ON ATHLETIC INJURIES

An "Athletic Injury Conference" was held recently in Dayton under the sponsorship of the Montgomery County Medical Society. It was for football coaches of the area.

Among subjects covered were the following: "Injuries to Abdomen and Genito-Urinary System (types of injuries, aids in evaluating their severity and what to do about them)"; "Head and Brain Injuries (protection to facial structures, the unconscious player, position and vital signs, the excited or groggy player)"; "Bones and Joint Injuries"; "Training of Athletes and Technique of Care of the Injured Athlete." There was an exhibit of protective devices and new and improved equipment.

The Montgomery County Medical Society is to be congratulated for having staged this timely and important conference—somewhat of an innovation, also. Other medical societies should consider arranging for the same kind of meeting and program. The general subject is one which deserves far more attention than it has had in the past.

PSYCHOLOGISTS AND TREATMENT OF DISEASE

Among questions which are submitted to the headquarters office of the OSMA from time to time, requiring an answer, this one bobs up occasionally: What are the priviliges and limitations of non-medical persons holding a degree in psychology who may engage in activities entailing the treatment of diseases?

Based on advice from the office of the State Medical Board, the reply to this question had been: A psychologist who treats diseases must either work under the direction and supervision

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of a licensed physician or must hold a limited license under the Ohio Medical Practice Act to practice psychotherapy or suggestive therapy or magnetic healing.

On this point, a statement issued recently by the American Medical Association is of value. It said in part:

"The application of psychological methods to the **treatment of illness is a medical function.** Any physician may utilize the skills of others in his professional work, but he remains responsible, legally and morally, for the diagnosis and for the treatment of his patient.

"The medical profession fully endorses the appropriate utilization of the skills of psychologists, social workers, and other professional personnel in contributing roles in settings directly supervised by physicians. It further recognizes that these professions are entirely independent and autonomous **when medical questions are not involved;** but when members of these professions contribute to the diagnosis and treatment of illness, their professional contributions must be coordinated under medical responsibility."

SEPARATE BILLS, SAYS JUDICIAL COUNCIL

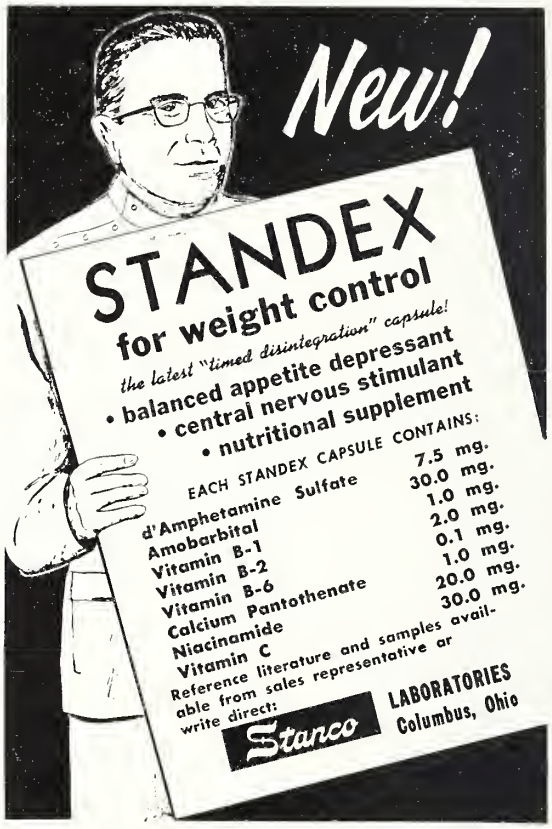
Maybe you've heard this question asked or asked it yourself:

"At my hospital we have neither interns nor residents to assist during surgery. The custom is for the surgeon to call in either the referring physician or another physician to assist him during surgery. May the surgeon ethically bill the patient for the total surgical charge and then reimburse the assistant personally out of the payment received from the patient?"

To get the accurate answer to this, let's look at what the Judicial Council of the American Medical Association said when the question was put to it. Here's the official opinion of that body:

"When two or more physicians actually and in person render services to one patient they should render separate bills. It is contrary to the traditions of the Association and spirit of the Principles for the surgeon to bill for the total surgical procedure and pay an assistant from the amount so received. The practice fails to impress patient with the gravity of surgical care—which is not a one-man procedure—and it tends to make the surgical fee appear disproportionately high.

"The Judicial Council suggests, in the best interest of the profession, that the patient be fully advised of the need for an assistant, and told that this is necessary in his own best interest. The patient should also be advised that the assistant will earn and charge a fee for his services and will send a bill for his services direct to the patient, which the patient should pay to the assistant."



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STARTING DATES — FALL, 1957

SURGERY—Surgical Technic, two weeks, Oct. 28, Nov. 11. Surgery of Colon & Rectum, one week, Oct. 7, Nov. 18. Basic Principles in General Surgery, two weeks, Oct. 14. Treatment of Varicose Veins, Oct. 14, Nov. 18. Thoracic Surgery, one week, Oct. 7. Gallbladder Surgery, three days, Nov. 4. Surgery of Hernia, three days, Nov. 7. General Surgery, two weeks, Sept. 23; one week, Oct. 28. Fractures & Traumatic Surgery, two weeks, October 21.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Oct. 21. Vaginal Approach to Pelvic Surgery, one week, Oct. 14. General & Surgical Obstetrics, two weeks, Nov. 4.

MEDICINE—General Review Course, two weeks, Sept. 23. Electrocardiography & Heart Disease, two weeks, Oct. 7. Gastroscopy & Gastroenterology, two weeks, Nov. 4. Dermatology, two weeks, Oct. 14.

PEDIATRICS—Pediatric Cardiology, two weeks, Dec. 2.

RADIOLOGY—Diagnostic X-Ray, two weeks, Sept. 16, Dec. 2. Clinical Uses of Radioisotopes, two weeks, Oct. 7.

UROLOGY—Two-Week Intensive Course, Oct. 7.

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1. Taylor, F. A.: Western J. Surgery, Obstetrics and Gynecology 64:280, 1956.

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Lull Named Assistant To AMA President; Blasingame Will Become General Manager

The American Medical Association has announced two important changes in its administrative setup.

The Board of Trustees elevated Dr. George F. Lull, of Chicago, who has been secretary-general manager of the Association for 11 years, to the newly-created position of assistant to the president of the AMA. He will continue serving as secretary, which is an elective office.

At the same time, the Board announced the appointment of Dr. F. J. L. Blasingame of Wharton, Texas, to the position of general manager of the American Medical Association. He will take over his new duties on January 1, 1958.

Dr. Blasingame, who is 50, has been active in medical affairs, both at the state and national level, for many years. When the AMA House of Delegates elected him as a member of the Board of Trustees in 1949 he was one of the youngest physicians ever chosen. Since then, he has held many important AMA committee appointments.

He served as president of the Texas State Medical Association in 1955.

After graduating from the University of Texas Medical School at Galveston in 1928, he spent three years as a teacher on the medical school staff. Ever since then he has maintained a teaching connection at the University of Texas.

In his new job, Dr. Lull will relieve the president of the Association of many of the burdens of this office, which have become especially heavy in the last few years.

Dr. Edwin S. Hamilton, chairman of the AMA Board of Trustees, said that "Dr. Lull will serve as spokesman, trouble-shooter, listening post, information center and as an ambassador of the medical profession in cities and towns throughout the country. His experience is invaluable, and it will be applied in solving medical problems at the state and local level, as well as nationally."

Dr. Lull, who is 70, joined the AMA staff after serving 34 years in the Army. He entered the Army in 1912 as first lieutenant, emerging as major general of the Army Medical Corps. His last position before retirement was deputy surgeon general of the Army.

Dr. Lull received many honors in connection with his Army service during both World Wars, including the Distinguished Service Medal. In 1951, the Cuban government gave him its highest honor— the Order of Carlos Findlay—for his humanitarian work in the field of medicine.

Dr. Blasingame will leave his private practice which he has carried on in the same location for 20 years, and will move his family to Chicago, as soon as possible. Dr. Blasingame has five children—three daughters, 22, 20 and 13, and two sons, 17 and 10.

Dr. Blasingame has long been active in civic affairs not only in his home town, but throughout Texas.

He is president of Blue Cross-Blue Shield Plans of Texas; he is chairman of the Board of Trustees of Wharton County Junior College, and he is also chairman of the medical advisory board of Sears, Roebuck Foundation, which encourages young doctors to create new medical facilities where they are needed.

Director of Council for Foreign Medical Graduates Named

Dr. Dean F. Smiley, who has been serving as secretary of the Association of American Medical Colleges for the last 10 years, has been named director of the newly formed Educational Council for Foreign Medical Graduates.

This council is the outgrowth of long planning by the AMA Council on Medical Education and Hospitals, the Association of American Medical Colleges, the Federation of State Boards of Medical Examiners and the American Hospital Association in an effort to develop a mutually acceptable means of verifying the educational background and qualifications of foreign medical school graduates.

For the time being, Dr. Smiley will carry on his work at the Association's offices in Evanston, Illinois.

The council is not concerned with the placement of individual foreign physicians in hospitals or with assisting individuals to obtain licenses to practice. Its chief function is to evaluate individual foreign graduates and to supply resulting information to state boards, hospitals and other agencies upon request. It will also assume the responsibility of furthering a student's medical education in this country if he has the right background and can benefit from it.

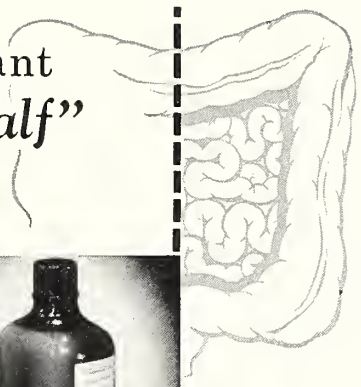
University of Cincinnati Research Projects Promoted by Grants

Dr. William B. Atkinson, associate professor in the University of Cincinnati College of Medicine, has been backed by a grant of $7,935 from the National Cancer Institute for his study of the possible role of endocrine imbalance in the development of Cancer of the uterine endometrium.

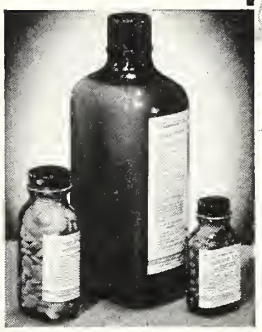
Dr. Roger C. Crafts, professor and head of the Department of Anatomy, and Dr. Howard A. Meinecke, assistant professor, are studying the role of endocrine glands in erythrocyte development, assisted by a $7,659 grant from the National Institute of Arthritis and Metabolic Diseases.

Dr. Meineke and Dr. Robert Binhamer, instructor in anatomy, are studying aspects of radiation sickness developing from exposure to x-rays, under a $14,171 grant from the National Cancer Institute.

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News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

Public Health Service grants for traineeships enacted by Congress in 1956 amount to $1,940,-021, including $1,020,143 to 230 physicians and other individuals, and $919,878 to 44 colleges and universities and 11 schools of public health to help train students selected by the schools.

* * *

The National Institutes of Public Health have granted $1,175,286 to Western Reserve University's Medical Center for construction of research laboratories, and, $26,250 for the WRU Institute of Pathology, for a remodeling program. The grants were made on a local matching fund basis.

* * *

U. S. Bureau of Public Assistance has reported that an incomplete survey indicates hospital care is the most expensive item in the medical care of persons supported by federal-state public assistance programs. For each such dollar spent, hospital care got 37.5 cents; nursing homes and home care maintenance, 29.5 cents; drugs and supplies, 13.8 cents, physicians' services, 13 cents, and other services, 7.9 cents.

* * *

The Cytoanalyzer, an electronic microscope which converts what it scans into an electron beam, is being installed by the National Cancer Institute and American Cancer Society at the University of Tennessee for large scale testing of its accuracy and speed in picking up abnormal cells on vaginal smear slides. It can screen slides almost as fast as they are fed in. The big question is whether or not its automatic segregation of suspicious cells from normal ones is as accurate as the microscope work of technicians.

* * *

Recently published statistical review and analysis of Hill-Burton program shows that since 10 years ago when the first grant was awarded, 3,514 projects have been approved to date, with an estimated total cost of $2,-874,587,085. One-third of the total represents the Federal contribution.

* * *

AMA and National Association of Radio and Television Broadcasters will meet in Chicago November 7 and 8 to discuss and analyze methods of improving television and radio presentation of medical subjects. Sponsored jointly by the two groups, the meeting was prompted by high public interest in medical subjects. Goal is to insure programs that are interesting, informative and factually correct.

AMA's 1955 president, Dr. Elmer Hess of Erie, Pa., has been named by President Eisenhower as chairman of the National Advisory Committee to Selective Service on the Selection of Physicians, Dentists and Allied Specialists. The committee advises on induction of medical and dental officers in the armed services.

* * *

Another foundation to raise public funds for support of research and fellowships has been announced. Its name is the National Neurological Research Foundation.

* * *

General Services Administration has awarded an architectural contract for plans for the new National Library of Medicine building. The new building will have 230,000 gross feet of air-conditioned space.

* * *

Surgeon General Burney has reported 68,-000,000 persons have had at least one shot of polio vaccine since it was first made available in 1955, and about 41 million persons under age 40 have had no injections. Three injections still are advised.

* * *

August saw more than 100,000 disabled workers receive checks under the Old Age and Survivors' Insurance disability payment program, which went into effect in July. These were the first such checks issued under the program.

Recent Civil Defense Publications

Your attention is invited to the following pertinent items in connection with civil defense:

"Atomic Tests in Nevada," U. S. Atomic Energy Commission, 1957.

"Defense Against Radioactive Fallout on the Farm," U. S. Department of Agriculture, 1957.

"Emergency Medical, Hospital, and Nursing Care," by Harold C. Lueth, M. D., The Annals of the American Academy of Political and Social Science, Vol. 309, January, 1957.

"Survival in Public Shelters," (A paper based on a technical study of hypothetical nuclear attack on the metropolitan area of St. Louis.) Federal Civil Defense Administration, 1957.

"Nursing During Disaster—A Guide for Instructors," Second Edition, National League for Nursing, 1957.

"Civil Defense and Vocational Education," American Vocational Association, Inc., 1010 Vermont Ave.. N. W., Washington 5, D. C.

Drivers Licenses for Epileptics . . .

New Law Goes into Effect September 17; Epileptics Whose Seizures Have Been under Medical Control for a Year Are Eligible To Apply

EPILEPTICS whose seizures have been under effective medical control for at least a year may apply for driver licenses under an act of the Ohio General Assembly which becomes effective September 17.

The new law provides that any person otherwise qualified but "subject to any condition which causes episodic impairment of consciousness or loss of muscular control" may apply for a license, provided he presents a statement from a licensed physician that his condition is under effective medical control. The statement also must include the period of time such control has been maintained.

Further provided is the right of appeal to a review board in event the registrar of motor vehicles sees fit to deny such an application.

The Governor is empowered to appoint one or more review boards to hear appeals. Each board is to consist of three members, and the law provides that one or more members shall be a physician qualified in the diagnosis and treatment of such diseases.

PROVISIONS OF THE LAW

The main provisions of the new law applying to licensure of such persons for driving are as follows:

Section 4507.08 (E) (1) A restricted license effective for six months may be issued to any person otherwise qualified who is or has been subject to any condition resulting in episodic impairment of consciousness or loss of muscular control and whose condition, in the opinion of the registrar, is dormant or is sufficiently under medical control that he is capable of exercising reasonable and ordinary control over a motor vehicle. A restrictive license, effective for six months, shall be issued to any person who is otherwise qualified who is subject to any condition which causes episodic impairment of consciousness or loss of muscular control if such person presents a statement from a licensed physician that his condition is under effective medical control and the period of time for which such control has been continuously maintained, unless, thereafter, a medical examination is ordered and, pursuant thereto, cause for denial is found. If cause for denial because of such condition is found and the period during which such condition was stated by a physician to have been under effective medical control was at least one year, the applicant shall have the right to a hearing before a review board constituted pursuant to subdivision (E) (2) of this section and shall be notified thereof in accordance with the provisions of section 119.07 of the Revised Code.

(2) The governor shall appoint members to one or more review boards which shall conduct hearings authorized by subdivision (E) (1) of this section. Each such board shall consist of three members and one or more of the members of each board shall be a physician qualified in the diagnosis and treatment of episodic disorders of consciousness or muscular control. The registrar shall immediately assign for hearing to a review board appointed pursuant to this paragraph appeals taken pursuant to subdivision (E) (1) of this section.

(3) Appeal to review boards constituted pursuant to subdivision (E) (1) of this section shall be conducted in accordance with and subject to applicable procedures and provisions of Chapter 119, of the Revised Code. In determining whether a person's condition is such that he can exercise reasonable and ordinary control over a motor vehicle while operating it upon the highways, due consideration shall be given to the extent and duration of medical control of the condition, whether the person may be depended upon to continue medication if continued medication is prescribed and all other relevant, competent and material evidence.

(4) The review board, after a hearing pursuant to subdivision (E) (3) of this section, shall approve, modify or reverse the decision of the registrar of motor vehicles and may order the issuance of a regular license or a restricted license effective for six months. The registrar shall comply with such order.

RESTRICTED LICENSES

(5) After a restricted license, effective for six months has been issued pursuant to the order of a review board, successive restricted six months' licenses may be issued by the registrar of motor vehicles upon receipt of a written statement of the applicant's attending physician that the applicant's condition has been continuously under medical control during the preceding six months and that he recommends a six months' extension of the license subject to continuation of treatment and re-examination by a physician within six months. If the applicant presents such statement, a license shall not be denied because of such condition unless a medical examination is undertaken and cause for denial of the license is found. If cause for denial because of such condition is found, the provisions of this section for notice and hearing before a review board shall apply.

You and Your AMA . . .

Some Highlights and Sidelights on What Your American Medical Association Is Doing in Its Extensive and Far-Reaching Program

THE medical profession and the broadcasting industry have joined in plans for a fall Conference on utilization of local radio and television time by medical and voluntary health organizations.

The two-day meeting—to be sponsored jointly by the American Medical Association and the National Association of Radio and Television Broadcasters—is set for November 7 and 8 at the Hotel Sheraton-Blackstone in Chicago.

The fall Conference is entitled "How to Use Local Television and Radio in the Health Field" and will be open to radio and television broadcasters, representatives of medical societies, hospital organizations, voluntary health organizations and others interested in public interest health programs.

Information concerning the meeting can be obtained from the American Medical Association, 535 North Dearborn, Chicago.

OHIOANS TO PARTICIPATE IN SYMPOSIUM ON SKIN

Three Ohio physicians will participate in the program of a symposium entitled "The Human Integument—Normal and Abnormal," scheduled in Indianapolis, Ind., December 28 and 29. They are Dr. Richard B. Stoughton, Cleveland; Dr. Raymond R. Suskind, Cincinnati, and Dr. A. Wesley Horton, Cincinnati.

The Committee on Cosmetics of the American Medical Association in co-sponsorship with the Society for Investigative Dermatology will present the two-day symposium. The program has been arranged at the invitation of the American Association for the Advancement of Science and will be presented before the Medical Sciences Section at the Association's 124th annual meeting.

Details may be obtained from the Committee on Cosmetics, AMA, 535 N. Dearborn St., Chicago 10, Illinois.

AMA TO STAGE FALL RURAL HEALTH MEETING

How to develop more effective rural health programs will be the chief topic of concern at the American Medical Association's second study conference October 4 and 5 for chairmen and members of state rural health committees. Sponsored by the Council on Rural Health, the conference will again be held at Purdue University.

The opening session will be devoted to a discussion of organizational techniques of statewide rural health committees. Another session will feature representatives of leading farm organizations outlining their health programs. Following this latter presentation will be a discussion of ways that the medical profession and agricultural groups can best work together in developing better health programs. Registrants also will have an opportunity to get together with others from their own regions to discuss mutual problems.

Reservations for this conference should be sent directly to Students Union, Purdue University, Lafayette, Indiana.

THREE NEW AMA EXHIBITS NOW AVAILABLE

Three new exhibits of the American Medical Association will be available for bookings by state and county medical societies in September.

(1) "Digestion"—shows the organs involved in digestion, the passage of food through the body, the mechanics of swallowing, the action of the stomach and intestines, and the body's absorption of food. (2) "Alcoholism Is Your Business"—(for professional audiences) gives the viewer an opportunity to eavesdrop on a conversation between a distraught spouse and the family physician over the treatment of alcoholism. (3) "Organs of the Human Body"—three dimensional models of the torso show location of various organs in the body and their functions.

Further information on these displays may be secured from the AMA Bureau of Exhibits.

COUNTY MEDICAL SOCIETIES CIVIL DEFENSE CONFERENCE

The eighth conference of the County Medical Societies civil defense organization has been scheduled for November 9-10, 1957, at the Morrison Hotel in Chicago, Illinois. This yearly conference is sponsored by the AMA Council on National Defense.

Dr. James H. Lade, of Albany, New York, and Dr. Thomas L. Meador, of Portland, Oregon, will serve as conference chairman and program chairman, respectively. Program plans are now under way and, at a later date, the completed program will be publicized.

AMA PLANS SCHOOL HEALTH CONFERENCE THIS FALL

"A Decade of Progress in Fitness" will be the theme of the sixth National Conference on Physicians and Schools to be held October 30 to November 2 at the Moraine-on-the-Lake Hotel, Highland Park, Illinois. Sponsored by the AMA's Bureau of Health Education, this year's program will emphasize a continuing interest in the health and all around fitness of children and youth.

More than 60 nationally recognized consultants

and resource persons have been selected from medicine, education and public health to lead the discussion groups. Topics to be considered include: the physician's role in youth fitness; community coordination; mental and emotional aspects of fitness; dramatizing basic fitness procedures; medical guidance in girls' recreation programs; special health problems in athletics; fitness of school personnel; optimum fitness for youth with special health problems; home and family relations; food factors in fitness.

As in previous conferences, state medical societies, state health and education departments, and national agencies concerned with school health and health education will send representatives.

AMA TO DEVELOP EMERGENCY MEDICAL CARE PLAN

At the request of the Federal Civil Defense Administration, the AMA will undertake a research study program to establish criteria for the provision of medical care of the surviving population (casualty and noncasualty) in the event of an enemy attack on this nation.

A special study committee, under the general direction of the AMA Council on National Defense, has been established for the initiation, planning and direction of the study with Harold C. Lueth, M. D., Evanston, Ill., temporary chairman. The committee selected the St. Paul - Minneapolis area in which to conduct the pilot study.

Since the program involves all-out mobilization of medical and health personnel, facilities, and supplies in time of grave national emergency, representatives of the FCDA, U. S. Public Health Service, and national medical and health associations will be requested to assist the special committee in the preparation of a national medical and health disaster preparedness program.

Mount Sinai Hospital, Fifth Ave., and 100th Street, New York 29, is offering a number of continuation training courses in clinical medicine given in affiliation with Columbia University. A catalogue of courses for 1957-1958 is available by writing to the hospital.

Extensive Building Program Under the State Mental Hygiene Program To Start This Fall

Dr. C. Earl Albrecht, an official of the State Department of Mental Hygiene and Correction, has pointed out that during the next three years almost $10,000,000 will be spent to build new institutions for the treatment and rehabilitation of mentally ill and delinquent children. Plans for additional institutions, costing $5,510,000, are scheduled to be submitted for approval of the 103rd General Assembly in 1959.

Three of the new institutions already approved will be for psychiatric treatment. They are: a $1,700,000 hospital at Sagamore Hills, between Cleveland and Akron; a $1,660,000 hospital at Dayton, and a $1,500,000 hospital at Columbus. The first two institutions will be under the jurisdiction of the Division of Mental Hygiene, which administers Ohio's mental health program, and the third institution under the Division of Juvenile Research, Classification and Training, which administers Ohio's program for problem juveniles, most of whom have been committed to the state by the juvenile courts.

Construction of the Columbus and Dayton institutions will get under way this fall. Construction of the Sagamore Hills institution will start next spring.

In addition to these hospitals for children, the Juvenile Diagnostic Center in Columbus will be doubled in size at a cost of almost $2,000,000, and the first phase of a new training institution for boys will be built in Central Ohio at a cost of $1,750,000. Construction of the Juvenile Center expansion will begin this fall and of the training institution next spring.

Youth camps, in the Juvenile Division, are being established at a cost of $250,000.

The 102nd General Assembly also appropriated $1,683,800 for the rehabilitation and repair of existing Juvenile Division facilities.

"Planned for submission to the 103rd General Assembly," said Dr. Albrecht, are "a Central Ohio training school for girls, to cost $1,100,000; completion of the training institution for boys to cost $1,750,000; a children's psychiatric hospital in southwest Ohio, to cost $1,700,000; adolescent units at Dayton State Hospital, to cost $480,000, and children's psychiatric units at Longview State Hospital, Cincinnati, also to cost $480,000."

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Medical Societies Challenged By Union Labor Bigwigs

A firm stand against the actions of medical societies who fail to go along with union labor medical programs has been agreed upon by the AFL-CIO committee on social security according to the "Summer Newsletter" recently issued by the Association of Labor Health Administrators. The ALHA is a group of medical directors, lay administrators, and other representatives of union health center plans.

The publication calls for action in opposing the "attack and harassment of component medical societies against union plans, particularly in the states of Pennsylvania, Illinois and Colorado." It states that at a meeting on May 15 in Washington, D. C. "at the merged headquarters," the AFL-CIO executive committee approved funds to encourage and promote the work of the ALHA in providing "technical aid to the trade union groups in development of better health service programs for the benefit of workers and their families."

The letter also stated that the association "will stand ready to bring experienced technical and legal counsel on request to the defense of the victims of any efforts on the part of medical power groups to destroy programs which endeavor to improve the quality and scope of prepaid health services available to working people and their families." The work will be carried out in cooperation with AFL-CIO through its department of social security.

The Newsletter used terms such as "medical power groups," "fee-minded physicians" and "monopolistic elements of organized medicine" in referring to the recent actions taken by medical societies in Pennsylvania, Illinois and Colorado.

Dr. Warren Draper's defense of the UMWA position opposing the "Suggested Guides to Relationships Between Medical Societies and the UMWA" was mentioned. These guides were adopted by the House of Delegates at its recent New York meeting.

Nutrition Study Among Projects Promoted at Western Reserve

Western Reserve University School of Medicine has received $71,044 in research grants from the National Institutes of Health of the Public Health Service.

Largest single grant went to Dr. David R. Weir for a study of nutritional factors in chronic illness. He is director of medical services at the new Highland View Hospital in Warrensville Township and an associate professor in the university's medical school.

He and a co-investigator, Dr. Oligard Linden, an assistant professor in the university's medical school, will explore the relation of nutrition to long-term illness.—*Cleveland Plain Dealer.*

Barhorst Convicted and Fined On Illegal Practice Charge

Letters bearing the heading, "Doctor Phillip V. Barhorst, Optometrist; Drugless, No Insulin, Diabetes Medicines or Tonics. No Drugs No Needles No Shots No Pills," have been circulating in Columbus.

The letters claim a treatment that eliminates diabetes in less than three months, eliminates asthma, bronchitis and colds in less than three months, and a treatment that makes the partly blind see well in less than three months.

On August 14, Barhorst, a Columbus resident, was fined $200 and costs in the Columbus Municipal Court after he was found guilty of practicing optometry without a license. Charges against Barhorst were filed by Arthur H. Cole, executive secretary and inspector of the Ohio State Board of Optometry. A motion for a new trial is pending.

State Board of Optometry records show Barhorst was issued a certificate to practice optometry under a "grandfather clause" in 1920 when the optometry law became effective, and that his certificate was revoked in 1932 for non-payment of renewal fee.

The records also show that Barhorst was found guilty in 1933 in the same court of charges, filed by the State Board of Optometry, of practicing optometry without a license. Barhorst was fined $100 and costs. The fine was suspended. He appealed to a higher court and his conviction was sustained.

In 1934, Barhorst was hailed into the same court on Ohio State Medical Board charges of illegal practice of medicine. He was found guilty and fined $100 and costs. Again, the fine was suspended. The case was appealed but no decision on the appeal was made until 1940, when the conviction was sustained.

The eighth annual conference of the National Association for Music Therapy will be held at the Michigan State University, East Lansing, October 10-12.

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In Memoriam . . .

Zelpha Walker Averill, M. D., Mansfield; Laura Memorial Woman's Medical College, Cincinnati, 1897; aged 84; died July 20; former member of the Ohio State Medical Association. Dr. Averill began practice in Benton Harbor, Mich., and moved to Mansfield in 1911 after her marriage to Rex G. Averill. She practiced there for a number of years, later retiring from practice in favor of civic affairs. She was active in such organizations as the local hospital advisory board, the YWCA, the Red Cross. She was a member of the Congregational Church, the DAR and the Round Table Club. Surviving are her husband, a daughter and a sister.

Arthur D. Blackburn, M. D., Circleville; Miami Medical College, Cincinnati, 1902; aged 77; died July 17; member of the Ohio State Medical Association and the American Medical Association. Dr. Blackburn began his practice in Wilmington upon completion of his medical schooling, later becoming successively teacher, principal and superintendent in the school system. He went to Circleville in 1937 as Pickaway County health commissioner, a post he held until last year. Surviving are his widow and two daughters.

Jacob Louis Bubis, M. D., Miami Beach, Fla.; University of Wooster, Medical Department, Cleveland, 1907; aged 72; died July 23; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; former chairman of the OSMA Section on Obstetrics and Gynecology; member of the Central Association of Obstetricians and Gynecologists; diplomate of the American Board of Obstetrics and Gynecology. A native of Cleveland, Dr. Bubis served his entire professional career in that city. He retired in 1954. A member of the American Medical Editors' and Authors' Association, Dr. Bubis was the author of two books and numerous articles in his specialty field. During World War II he served on the local council for civil defense. Surviving are his widow and two daughters, one of whom is Mrs. David Clayman (Dr. Sylvia Bubis), Columbus.

Donald M. Cavanaugh, M. D., Wyoming; Eclectic Medical College, Cincinnati, 1923; aged 58; died July 17; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Cavanaugh practiced in the Greater Cincinnati area, with office in Reading, for 33 years. In addition to his professional organizations, he was a member of the Catholic Church, the Knights of Columbus, the Knights of St. John and Order of Eagles; he was also active in Boy Scout work. Surviving are his widow, two sons, two daughters, two sisters and two brothers, one of whom is Dr. H. Norbert Cavanaugh, also of Wyoming. Dr. Robert J. Duffner, who was associated with Dr. Cavanaugh in practice, is a nephew.

Phrania Chesbrough, M. D., Atlanta, Ga.; Ensworth Medical College, St. Joseph, Mo., 1899; aged 86; died July 6; former member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award. One of the pioneer women physicians in Greater Cleveland area, Dr. Chesbrough practiced a lifetime in Willoughby and vicinity, where she also was physician for the Andrews School for girls. She retired in 1951 and moved to Atlanta where she resided with a niece.

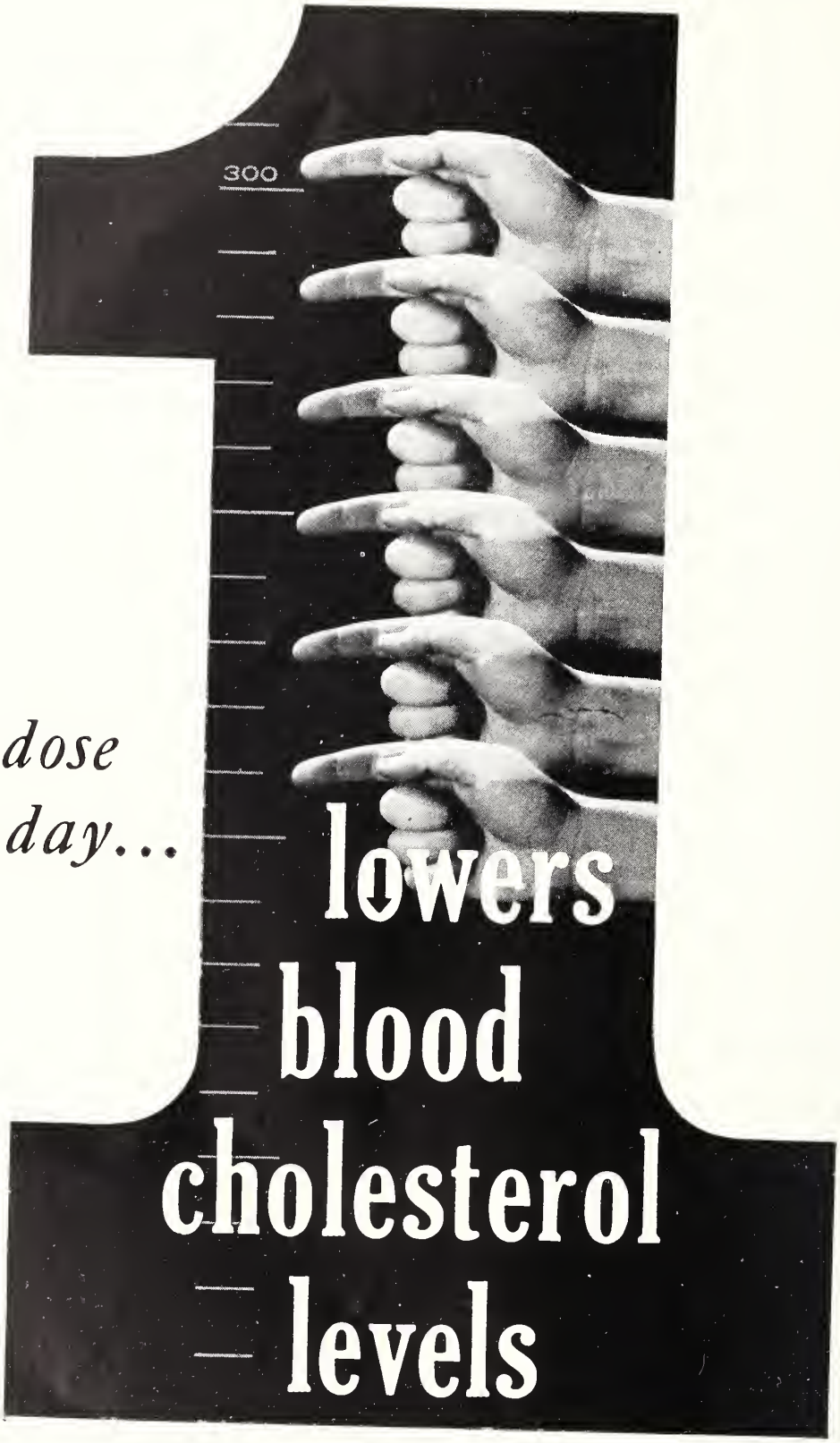
Frederic C. Gilcher, M. D., Cherryplain, N. Y.; University of Michigan Homeopathic Medical School, 1896; aged 83; died July 1. Dr. Gilcher practiced a total of 53 years in Seneca County before his retirement in 1949. He was in Republic until 1918 and then moved to Tiffin. Survivors include a son, a stepson and a stepdaughter.

Louis L. Lieberman, M. D., Shaker Heights; Western Reserve University School of Medicine, 1922; aged 59; died July 26; member of the Ohio State Medical Association and the American Medical Association. Dr. Lieberman practiced medicine in Greater Cleveland for 35 years, with time out during World War II for service in the Medical Corps. He was a member of Phi Delta Epsilon, the Oakwood Country Club and the Temple. Surviving are his widow, a daughter and three sisters.

Oscar R. Micklethwait, M. D., Portsmouth; Medical College of Ohio, Cincinnati, 1906; aged 75; died July 31; member of the Ohio State Medical Association and the American Medical Association; past-president of the Scioto County Medical Society. Member of a pioneer family of the area, Dr. Micklethwait was born near Portsmouth and served all of his professional career in the Portsmouth vicinity. In 1956 he was honored by the Scioto County Medical Society when he was presented the 50-Year Award. In recent years he devoted much of his time to real estate development, and to his work as head of the Carrs Fork Coal Company. He was a member of the Methodist Church, the Odd Fellows and was a 32nd Degree Mason. A widower, he is survived by a sister.

Newton Melville Reiff, M. D., Washington C. H.; Western Reserve University School of Medicine, 1931; aged 52; died July 30; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A native of Marion, Dr. Reiff completed his medical schooling in Cleveland and also did intern and residency there, moving to Wash-

(Continued on Page 1072)


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ington C. H. 22 years ago. In addition to his private practice, he was Fayette County coroner. His interests extended to a number of organizations, but in recent years outside activities centered in the Heart Association and Cancer Society. Mrs. Reiff is well known in the Woman's Auxiliary work, being a former state president. Also surviving are two daughters and his father.

Elvie C. Sherman, M. D., Cardington; Starling Medical College, Columbus, 1896; aged 86; died July 27; former member of the Ohio State Medical Association. Dr. Sherman practiced his profession for 40 years in Cardington after moving there from Fulton. He was a member of the Masonic Lodge and the Knights of Pythias. Surviving are his widow, two sons and two brothers.

Lewis A. Smith, M. D., Mansfield; Ohio Medical University, Columbus, 1897; aged 83; died July 20; member of the Ohio State Medical Association and the American Medical Association. Dr. Smith moved to Mansfield in 1925 from Franklin, Mass., where he formerly practiced. He was a member of the Congregational Church. Surviving are his widow, two daughters and a son, Dr. William A. Smith, of Columbus.

Marlin R. Wedemeyer, M. D., Columbus; Ohio State University College of Medicine, 1933; aged 49; died July 30; member of the Ohio State Medical Association, the American Medical Association and the American Psychiatric Association. Dr. Wedemeyer had been superintendent of the Columbus State Hospital since 1952. Before that assignment he was director of the Toledo Mental Hygiene Center and still earlier was director of the counseling and diagnostic clinic at the Ohio Penitentiary. During World War II, Dr. Wedemeyer was with the Air Force Medical Corps and earlier served with the Army Medical Corps. He was affiliated with a number of professional organizations and was a member of several Masonic bodies. Surviving are his widow, three half sisters and five half brothers.

Ivan C. Wohrley, M. D., Newark; Eclectic Medical College, Cincinnati, 1922; aged 63; died July 5. Dr. Wohrley had been a physician in Newark for more than 15 years. He previously practiced in Columbus and at one time was in Hilliards.

Irvin S. Workman, M. D., Mt. Vernon; Western Reserve University School of Medicine, 1903; aged 87; died July 6; former member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award. Dr. Workman served all of his professional career in Knox County, having practiced for five years in Gambier before he moved to Mt. Vernon. A member of the American Legion, he served as captain in the Medical Corps during World War I. He also was a member of the Methodist Church. Surviving are his widow, two daughters, and two sons and a brother.

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Do You Know . . . .

Dr. Clayton S. Smith, chairman of the Department of Physiological Chemistry and Pharmacology at the Ohio State University, retired from that position on July 1 after 37 years of service.

* * *

Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, has been appointed a member of the Advisory Board of the Toswell Park Memorial Institute of the University of Buffalo School of Medicine.

* * *

John Richard Baringer, Columbus, who is entering his third year at Western Reserve University School of Medicine, has been awarded a $500 scholarship for research and clinical training this summer in the field of the allergic diseases, by the American Foundation for Allergic Diseases.

* * *

Dr. Myron Leon, St. Luke's Hospital, Cleveland, associate in surgical research, has been awarded grants by the National Institutes of Health amounting to $47,100. With the assistance of two exchange fellows from Germany, Dr. Klaus Rother and Dr. Ursula Rother, he will study properties of the defensive proteins, complements and properdin.

* * *

Officers for the current year for the American Medical Women's Association, Branch 11 of Southwest Ohio, are the following: Dr. Rae Hartman, 2002 Madison Road, Cincinnati 8, president; Dr. Jeanne Nitchals, Cincinnati; vice-president; Dr. Emily Wright, 421 Burns Ave., Cincinnati 15, secretary; and Dr. Eileen O'Ferrell, Cincinnati, treasurer.

* * *

Dr. Jonathan Forman, Editor of *The Journal*, recently was accorded the honor of a personal conference with President Eisenhower. The visit was in connection with Malabar Farm, estate of the late Louis Bromfield. Friends of the Land, an organization dedicated to soil and water conservation, of which Dr. Forman is president, is converting Malabar Farm into a permanent educational and research center.

* * *

New editor-in-chief of the *American Journal of Pathology*, official organ of the American Association of Pathologists and Bacteriologists, is Dr. Edward A. Gall, professor and head of the Department of Pathology at the University of Cincinnati. He is also secretary of AAPB.

* * *

Dr. Franz Alexander, Los Angeles, Calif., Hungarian-born psychiatrist, has been appointed part-time visiting professor of psychiatry in the University of Cincinnati College of Medicine.

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Information For Nurses On Holding License and Renewal of Same

The Ohio Board of Nursing Education and Nurse Registration has warned that employers of nurses and nurse registries should make an annual check of the current registration or licensure status of nurse employees or registrants, and should check also the current registration or licensure status of each applicant.

Every nurse who is currently registered or licensed in Ohio has been issued evidence of her current registration or licensure, and should be required by her employer to show this evidence. Special note should be made of the expiration date. An expired license is not valid.

The Ohio Nursing Practice Act requires that any nurse who wishes to practice legally in Ohio as a registered professional nurse, must be currently registered by renewing her certificate of registration annually.

All Ohio registered nurses who renewed their certificates of registration for 1957 have been issued certificates for 1957 which will expire on February 28, 1958. All nurses who were registered for the first time in Ohio after December 1, 1956, were issued identification cards. They are currently registered until February 28, 1958 when their original certificates expire and must be renewed annually.

A nurse who practices as a registered nurse in Ohio without a current certificate of registration, is practicing illegally in this State and is subject to the penalties provided in the Nursing Practice Act.

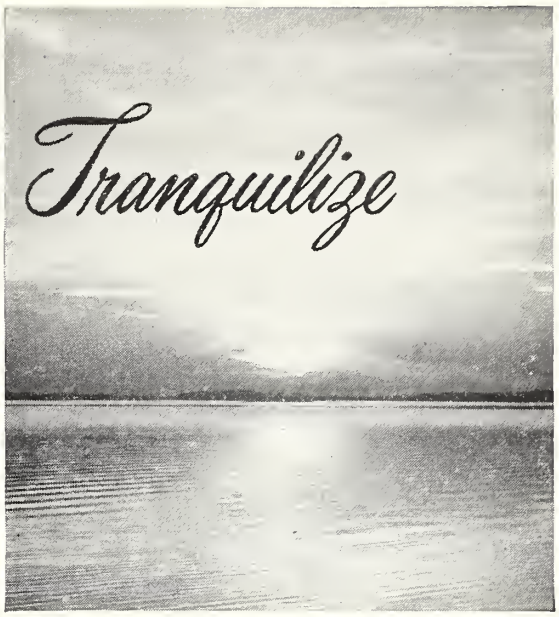
By law, a practical nurse cannot practice in Ohio as a licensed practical nurse after March 31, 1958, if she has not been licensed in this State.

Experienced practical nurses who are **not** graduates of approved schools of practical nursing and, who wish to be licensed with or without examination, are required by law to file their applications **before** December 31, 1957.

After March 31, 1958, only graduates of approved schools of practical nursing are eligible by law to be licensed in Ohio.

Annual renewal of the practical nurse license is not required by law until 1958. All Ohio practical nurses who have been licensed since January 1, 1956, are currently licensed until August 31, 1958 when their original licenses expire and must be renewed annually if they wish to continue to practice in Ohio as licensed practical nurses.

Miss Celia Cranz, R. N., executive secretary of the Ohio State Nurses' Association, has announced her desire to retire from that position as soon as possible. She wants to retire to the restored century-old home on the original Cranz farm in Summit County. Another vacancy in the staff is left by the resignation of Mrs. Julia Fishbaugh, R. N., associate executive secretary. Her plans for the future have not been announced.



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Activities of County Societies . . .

FRANKLIN

With no meetings scheduled during the summer, the next regular program of the Columbus Academy of Medicine will be October 5. Designated "Clinic Day," the program will include discussion by prominent speakers of the following subjects: Gout and gouty arthritis, biliary tract lesions, psychiatric problems in the aged, cancer of the prostate, infections in the newborn and breast lesions.

PORTAGE

On June 18, 1957, a steak dinner at Cherry's in Ravenna was enjoyed by those members of the Portage County Medical Society present. Refreshments were courtesy of Drs. Huffman and Roy. An excellent talk on the Practical Management of the Hemiplegic was given by Dr. Mieczyslaw Pesczynski, assistant professor of physical medicine, Highland View Hospital, Cleveland.

On July 17 at the Robin Hood Restaurant in Kent, a luncheon business meeting was held. A new Portage County Medical Society Constitution and Bylaws was read. It was similar to the model presented by the Ohio State Medical Association but differed in two major points. The Portage County Medical Society members felt that since a five-year residency in the United States was necessary before a petition for citizenship could be filed that this wording unfairly discriminated against the immigrant physician who might be licensed to practice in Ohio. It was felt that if the State of Ohio saw fit to license a physician, then the county society should not discriminate against the physician merely on the basis of national origin.

The Society also felt that the inclusion of compulsory membership in the Ohio State Medical Association for all members was unfair. Either it should remain voluntary, or if compulsory, it should include compulsory membership in the American Medical Association. In view of the national character of so much of medicine today, the latter view was adopted. The Constitution and Bylaws was changed to include compulsory membership in both the Ohio State Medical Association and the American Medical Association for all members of the Portage County Medical Society. It should be pointed out that at present the Portage County Medical Society has 44 members, all of whom are members of the Ohio State Medical Association and the American Medical Association.—Arthur L. Knight, M. D., Secretary-Treasurer.

Dr. Haines Named To Head Department of Mental Hygiene and Correction

Dr. Robert A. Haines, superintendent of Longview State Hospital, Cincinnati, has been named to become director of the State Department of Mental Hygiene and Correction, by Governor C. William O'Neill.

This Department comprises the Division of Mental Hygiene; the Division of Correction, and the Division of Juvenile Research, Classification and Training. The post as director is that formerly held by Dr. John D. Porterfield, who resigned in October, 1956 to accept an appointment with the U. S. Public Health Service in Washington. Since then Dr. C. Earl Albrecht has been acting director.

A native Ohioan, Dr. Haines graduated from the University of Cincinnati College of Medicine in 1942. During World War II he served three years on military duty, 19 months in Europe. Dr. Haines has been on the staff of the Longview Hospital since 1948, first as assistant superintendent and later as superintendent. He has been certified by the American Psychiatric Association as a mental hospital administrator.



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Rutin	10 mg.	Niacinamide	20 mg.
Ascorbic Acid	30 mg.	Manganese	1 mg.
B-12	1 mcg.	Magnesium	5 mg.
Molybdenum	0.5 mg.	Iodine	0.15 mg.
Cobalt	0.1 mg.	Potassium	2 mg.
Copper	0.2 mg.	Zinc	1 mg.
Vitamin A	5,000 I.U.	Choline Bitartrate	40 mg.
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*REFERENCE: J.A.M.A. 163: 359, 1957 (February 2)

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Birth Certificate Scheme Nipped

Kenneth R. Ogle and Roger W. Amstutz, partners operating the Birth Certificate Service at Cincinnati and Columbus, also Washington, D. C., have signed an affidavit with the Postal Inspection Service stating they would discontinue and abandon the use of the mails in the conduct of the enterprise described in the P. O. complaint to be unlawful, and that they will make no further mailings of the materials and that the affidavit was being made for the purpose of having the Assistant General Counsel, Fraud Division, of the Post Office Department suspend further proceedings that had been instituted against the partners. Reference was made to this outfit in the July *Journal*.

COMING MEETINGS

American Medical Association, Clinical Meeting, Philadelphia, December 3-6.

American Medical Writers' Association, 14th Annual Meeting, Sheraton-Jefferson Hotel, St. Louis, September 27-28.

Indiana State Medical Association, Annual Meeting, French Lick, October 6-9.

County Medical Societies, Civil Defense Organization, Eighth Conference, sponsored by AMA, Morrison Hotel, Chicago, November 9-10.

Course in Pulmonary Diseases, Ohio State University, September 27-28.

Course in Radiation for Industrial Physicians and Lawyers, University of Cincinnati, Week of September 9.

Eighth Councilor District Meeting, Marietta, October 3.

Kentucky State Medical Association, Annual Meeting, Louisville, September 17-19.

Medical Society of the State of Pennsylvania, Annual Meeting, Pittsburgh, September 15-20.

Michigan State Medical Society, Annual Meeting, Grand Rapids, September 25-27.

Northwestern Ohio Medical Association, Annual Program, Defiance College, Defiance, October 23.

Occupational Skin Problems, Institute of Industrial Health, University of Cincinnati, October 28 - November 1.

Ohio Academy of General Practice, Seventh Annual Scientific Assembly, Columbus, September 18-19.

Ohio Chapter, American College of Surgeons, Second Annual Meeting, Toledo, September 6-7.

Sixth Councilor District Postgraduate Day, Canton, October 23.

Cleveland's first drive-in professional office building—the University-Cedar Medical Center at 10900 Carnegie Avenue— was opened recently. The six-story building contains 43 physicians' and dentists' suites. Patients drive into the autolanai where they leave their cars with attendants.

INDEX TO ADVERTISERS

Abbott Laboratories ..... Insert Between Pages I064-1065
American Meat Institute 989
Ames Company, Inc. 1088
Appalachian Hall 1004
Armour Laboratories, The 1070-1071
Ayerst Laboratories, Inc. ..... Pages 1072, 1076, and Insert Between Pages 1076-1077
Baker Laboratories, Inc. 996
Barry Laboratories, Inc. 1000
Bayer Company, The, Div. of Sterling Drug Co., Inc. 1099
Burroughs, Wellcome & Co. (U.S.A.) Inc. 1055, 1073, 1097
Ciba Pharmaceutical Products, Inc. 1096
Columbus Pharmacal Company 1053
Cook County Graduate School of Medicine 1060
Corn Products Refining Co. 1094
Davies, Rose & Co., Ltd. 1074
Dearborn Inn 1004
Endo Products, Inc. 1090
Flint, Eaton & Company 982
Geigy Pharmaceuticals, Inc. 1008
Harding Sanitarium 1006
Hoffmann-LaRoche, Inc., ... 1082-1083 Insert Between Pages 1036-1037
Knox, Chas. B., Gelatine Co., Inc. 1007
Lakeside Laboratories, Inc. 981
Lederle Laboratories 995, 999, 1042,-1043, 1075, 1089, 1098
Lewal Pharmaceutical Company 988
Lilly, Eli, and Company 1012
Lloyd Brothers, Inc. 1091
Loma Linda Food Company 998
Mallard, Inc. 1077
McMillen Sanitarium 1006
Medical Protective Company 1056
Merck Sharp & Dohme 993, 997, 1089
Neil Training School 1067
New York Polyclinic Medical School 1075
North, Emerson A., Hospital, The 1057
Parke, Davis & Company ..... 1001-1002-1003, 1109 and Inside Back Cover
Pfizer, Chas. & Co., Inc. 1095
Picker X-Ray Corporation 1092
Pogue, Mary, School, Inc. 1081
Quincy X-Ray & Radium Lab 1068
Rich Company, Inc. 1059
Riker Laboratories, Inc. 1035
Robins, A. H., Co., Inc. 1053, 1085
Roerig, M. B., & Co. 1087
Sawyer Sanatorium 1099
Schering Corporation 986-987, 1010-1011
Scroggins, Clayton L., Associates (Medical-Dental Management) 1098
Searle, G. D., & Company 1051
Smith, Kline & French Laboratories ..... 1086 and Back Cover
Squibb, E. R., & Sons, Division of Olin-Mathieson Chemical Corporation 1084
Stanco Laboratories 1060
Stoneman Press 999
Tutag, S. J., & Company 1089
U. S. Vitamin Corporation 1061
Wallace Laboratories ..... Insert Between Pages 1048-1049
Warren-Teed Products Company, The 1063
Wendt-Bristol Company 1056
Windsor Hospital, Inc. 1078
Winthrop Laboratories ..... 900 - 991

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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PHYSICIAN'S OFFICE FOR RENT: Well established general practice; office equipment and furniture for sale. Mrs. Robt. A. Thornton, 43 E. Tompkins St., Columbus 2, Ohio; Phone AM 2-9829.

WANTED: Pediatrician, general practitioner, or internal medical man to join four other physicians in an active group practice. Guaranteed salary first year. Partnership in two years. Contact Dr. Wertheimer, 211 Third Street, Fairport Harbor, Ohio. Phone Elmwood 4-4366.

WELL TRAINED FEMALE PHYSICIAN, Ohio license, wishes full or part time position at Industrial Clinic, or in association with general practitioner in Cleveland. Box 948, c/o Ohio State Medical Journal.

LOCUM TENENS wanted in general practice, suburb of Dayton. Salary $800 - $1,000 per month. Write Box 950, c/o Ohio State Medical Journal.

EQUIPMENT FOR SALE: Walker ophthalmic high frequency unit type 1400 equipped for retinal detachment procedures, 4 yrs. old and brand new—never once used. Make offer. Will consider trade on Minifon P-55-S or Polaroid Pathfinder. P. O. Box 51, Tiffin, Ohio.

X-RAY: 200 M. A. Westinghouse; spot film; rotating anode tubes; complete. Used two years. Radiologist owner. Box 952, c/o Ohio State Medical Journal.

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PRACTICE, OFFICE, EQUIPMENT AVAILABLE: Large general practice of the late Dr. M. N. Reiff, Washington Court House, available. Office, with living quarters connected, if desired; equipment for sale. Write or phone Mrs. M. N. Reiff, 404 Rawlings St., Washington C. H., Ohio.

OFFICES FOR SALE: Arranged for physician or dentist. Excellent location. 4 room apt.; lot 90x200. Asking price $29,000. Springfield, Ohio. Box 953, c/o Ohio State Medical Journal.

FOR RENT: Large room next to drug store, easily adapted for doctor's office. Private blacktop parking. Berwick area of Columbus. Telephone BElmont 1-9458, Columbus, Ohio.

May Institute of Cincinnati Gets Improvement Grant

The Jewish Hospital Association, Cincinnati, announced that the U. S. Government, under the Health Research Facilities Act, has allocated $37,500 toward a $75,000 program of laboratory improvements and additions at the Association's May Institute for Medical Research. Under the act, the federal grant must be matched locally.

The program will permit construction of a new suite of laboratories in the lower level of the present building as well as provide improvements on the other three floors. The institute conducts research on high blood pressure, heart disease, kidney failure, aging of blood vessels and other disabling diseases.



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A. Marsilid (iproniazid) is an amine oxidase inhibitor which affects the metabolism of serotonin, epinephrine, norepinephrine and other amines.

Q. How does Marsilid act?

A. Marsilid has a normal eudaemonic* rather than an abnormal euphoric effect; it promotes a feeling of well-being and increased vitality; it restores depleted energy and stimulates appetite and weight gain in chronic debilitating disorders.

Q. How soon is the effect of Marsilid apparent?

A. Marsilid is a slow-acting drug. In mild depression it usually takes effect within a week or two; in severe psychotics, results may be apparent only after a month or more.

Q. What are the indications for Marsilid?

A. Mild depression in ambulatory, non-psychotic patients; psychoses associated with severe depression or regression; stimulation of appetite and weight gain in debilitated patients; chronic debilitating disorders; stimulation

*Eudaemonia is a feeling of well-being or happiness; in Aristotle's use, felicity resulting from life of activity in accordance with reason.

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(Continued on next page)

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ADAMS—Sam C. Clark, President, Cherry Fork; Hazel L. Sproull, Secretary, West Union. 3rd Wednesday, April, June, August, October, December.

BROWN—John R. Donohoo, President, Georgetown; Leslie Hampton, Jr., Secretary, Sardinia. 1st Sunday, monthly.

BUTLER—Ralph H. Leyrer, President, Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton. Beginning in February 4th Wednesday of alternate months.

CLERMONT—Charles M. Simmons, President, Bethel; John T. Crone, Secretary, Milford. 3rd Wednesday, monthly.

CLINTON—John K. Williams, President, Wilmington; Edmond K. Yantes, Secretary, Wilmington. 1st Tuesday.

HAMILTON—George X. Schwemlein, President, Cincinnati; Mr. Edward F. Willenborg, Executive Secretary, 152 East 4th Street, Cincinnati. 2nd Tuesday, monthly.

HIGHLAND—Richard C. Wenrick, President, Hillsboro; Leland Dale McBride, Secretary, Hillsboro. Selected monthly.

WARREN—Howard G. Berninger, President, Lebanon; D. Paul Ward, Secretary, Pleasant Plain. 2nd Tues., monthly.

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CLARK—John D. LeFevre, President, Springfield; Charles E. Fralick, Secretary, Springfield. 3rd Monday, monthly.

DARKE—E. Westbrook Browne, President, Greenville; Maurice M. Kane, Secretary, Greenville. 3rd Tuesday, monthly, except June, July, August, December.

GREENE—Joseph R. Schauer, President, Fairborn; Norman G. Linton, Secretary, Jamestown. 2nd Thursday, monthly.

MIAMI—Charles M. Oxley, President, Troy; Dale A. Hudson, Secretary, Piqua. 1st Friday, monthly, except July, August.

MONTGOMERY—R. Dean Dooley, President, Dayton; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Building, Dayton. 1st Friday, monthly, except July, August and September.

PREBLE—E. P. Trittschuh, President, Lewisburg; John R. Bowman, Secretary, Eaton. November of each year.

SHELBY—James W. Tirey, President, Anna; Robert H. Lanfersieck, Secretary, Sidney. 1st Tuesday, monthly.

THIRD DISTRICT

ALLEN—David L. Steiner, President, Lima; Thomas D. Allison, Secretary, Lima. 3rd Tuesday, monthly, except June, July and August.

AUGLAIZE—William V. Barton, President, St. Marys; Dale L. Kile, Secretary, St. Marys.

CRAWFORD—Charles J. Griebling, President, Galion; James E. Loggins, Secretary, Galion. 3rd Friday, monthly.

HANCOCK—R. Grant Janes, President, Findlay; Benjamin H. Saunders, Jr., Secretary, Findlay. 3rd Tuesday, monthly.

HARDIN—Richard A. Dietrich, President, LaRue; Wm. F. Binkley, Secretary, Kenton. 2nd Tuesday, monthly.

LOGAN—Charles H. Thompson, President, West Mansfield; Charles A. Browning, Jr., Secretary, Bellefontaine.

MARION—John T. Boxwell, President, Marion; Thomas N. Quilter, Secretary, Marion. 1st Tuesday, monthly.

MERCER—Robert M. Fell, President, Celina; Julius Schwieger, Secretary, Fort Recovery. 3rd Thursday, monthly.

SENECA—Leonard M. Gaydos, President, Tiffin; Thomas W. Watkins, Secretary, Tiffin. 3rd Tuesday, monthly.

VAN WERT—Edwin Wm. Burnes, President, Van Wert; Norman L. Marxen, Secretary, Van Wert. 1st Friday.

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County Societies' Officers and Meeting Dates (Continued)

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(1) Asung, C. L.; Charcowa, A. I., and Villa, A. R.: Sea View Hosp. Bull. *16*:80, 1956. (2) Asung, C. L.; Charcowa, A. I., and Villa, A. R.: New York J. Med. *57*:1911 (June 1) 1957. (3) Report on Field Screening of Nostyn by 99 Physicians in 1,000 Patients, June, 1956.

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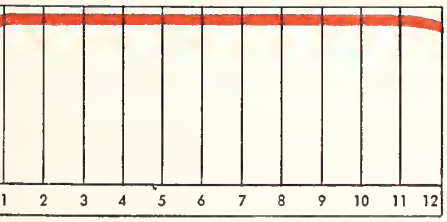
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Epilepsy and the Law. A Proposal for Legal Reform in the Light of Medical Progress, by Roscoe L. Barrow and Howard D. Fabing, M. D. ($5.50. *A Hoeber-Harper Book, New York 16, New York.)* The book shows how the present laws regarding the disease came into being; what have been their effects; why a reappraisal of our laws governing issuance of drivers' licenses to epileptics, how Workmen's Compensation Laws work against the epileptic and what steps to reform the laws should be taken.

Psychoanalysis and Psychotherapy, by Franz Alexander, M. D. ($4.75. *W. W. Norton & Co., New York 3, N. Y.)* The director of the Chicago Institute of Psychoanalysis presents here new viewpoints on the application of psychological principles to therapy. He points out that important changes have taken place as a result of a growing acceptance of psychoanalysis by the medical community. More and more, doctors are becoming aware of the great possibilities of applying the knowledge we have gained in a broad way for treatment purposes. Important groups of patients can be greatly benefited by "dynamically oriented" psychotherapy, with its less complete and less intensive treatment.

The Effects of Mothers' Diet on the Intelligence of Offspring, by Ruth Harrell, Ella Woodyard, and Arthur Gates. ($1.00. *Bureau of Publications, Teachers College, Columbia University, New York, N. Y.)* This is a study of the influence of vitamin supplementation in the diets of pregnant and lactating women on the intelligence of their children.

Some Aspects of Amino Acid Supplementation, edited by William H. Cole. ($2.00. *Rutgers University Press, New Brunswick, N. J.)* This is the report of the annual conference on protein metabolism held at Rutgers University. It is a review by six speakers at that conference who discussed freely the work in their particular portion of the field, and presented it against the background of other contributions to the subject.

Metabolism and Function of Iron, A report of the 19th Ross Pediatric Research Conference. (Apply. *Ross Laboratories, Columbus 16, Ohio.)* This conference held under the auspices of the Department of Pediatrics of the University of Oregon and the University of Washington School of Medicine in Portland in October of 1955. The purpose of the conference was to bring together leaders in the field of iron and porphyrin metabolism, and to arrange a program devoted entirely to fundamental biochemical metabolism and concepts, rather than purely considerations.

The Biology of Senescence, by Alexander Comfort. ($4.00. *Rinehart and Co., New York 16, N. Y.)* Throughout history man has recognized that he and his domestic animals will undergo adverse changes with the passage of time. The close involvement of these observations with human fears and aspirations accounts for the very extensive metaphysical literature on aging. Interesting psychological and historical speculations could be made on the part which awareness has played in human affairs. It is the attempt to approach the study of aging without any bias which makes this book so interesting and important. In this sense, sensecence is regarded as the general title for the group of effects which in the various phyla lead to a decreasing expectation of life, with increasing of aging. Everyone interested in gerontology and geriatrics will find this book most informative and stimulating. There is also a very extensive and valuable bibliography.

Ankylosing Spondylitis: Clinical Considerations; Roentgenology; Pathological Anatomy; Treatment, by J. Forestier, M. D., F. Jacqueline, M. D., and J. Rotes-Querol, M. D., translated by A. V. DesJardins. ($10.75. *C. C. Thomas, Publishers, Springfield, Ill.)* This volume has been written for the internist and surgeon who devote attention to the different types of arthritis and rheumatic diseases in general, and for the roentgenologists who are often called upon to examine cases of this kind, and for the general practitioners who are so frequently the first to be consulted by patients who are afflicted by these diseases. Correct stress is placed upon thorough examination, and the numerous roentgenograms included as illustrations are especially valuable.

The Rape of the Mind, by Joost A. Meerloo, M. D. ($5.00. *World Publishing Co., Cleveland 2, Ohio.)* This book treats of the psychology of thought control, menticide, and brain washing. Since 1933, when a completely drugged and trial-conditioned human wreck confessed to having started the Reichstag fire in Berlin, the author has studied the methods by which systematic pressure brings people to abject submission, and by which totalitarians imprint their subjective "thought" on their victims' minds. He witnessed at first hand the Nazi methods of mental torment in Holland during the first two and one-half years of World War II. He escaped from prison and became chief of the Psychological Department of the Netherlands forces. In this capacity he investigated not only traitors but also those members of the Resistance who had undergone the utmost of mental pressure. As more and more of thought control, brain washing, and mental coercion were disclosed,

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notably Cardinal Mindszenty, Colonel Schwable, and Robert Vogeler and others, his interest grew. He served as an expert witness in the case of Colonel Schwable. So here is an authoritative work. Not only does the author show the methods of the totalitarians and their success in turning men into traitors, but he also describes how our own culture unobstrusively shows symptoms of pressurizing people's minds. In this new phase of the cold war, with its mental terror, its "verbocracy," and semantic fog, fear becomes a tool for mass submission, and the problem of treason and loyalty becomes loaded with dangerous confusion.

1955-1956 Yearbook of Dermatology and Syphilology, by Rudolf L. Baer, M. D., and Victor H. Witten, M. D. ($6.50. *Yearbook Publishers, Chicago 11, Illinois.)* This review is up to its usual standard. The introductory essay to which we all look forward each year, bears on certain selected aspects of dermatological therapy when superficial x-ray and grenz rays are used. As in all fields of medicine, we begin to find much mention of cutaneous enzymes.

Nursing Care of the Newly Born Infant, by William S. Craig with the collaboration of M. F. G. Buchanan, R. J. Pugh, Miss M. Pattullo, and Miss M. J. W. Taylor. ($7.00. *E. S. Livingstone Ltd., Edinburgh;* United States Distributor, *Yearbook Publisher, Chicago, Ill.)* The emphasis of this book is based on the fundamental importance of clinical observation in the professional care of newborn infants. Although intended primarily for the midwife and the family doctor, it will prove of value to all concerned with clinical problems presented by the newborn infant.

Golden's Diagnostic Roentgenology, Radiology of the Heart and Great Vessels, by R. N. Cooley and R. D. Sloan, with Loose Leaf Cover. ($15.00. *Williams and Wilkins, Baltimore 2, Md.)* This work has been completely revised and brought up to date in 306 pages.

Mental Hygiene, Dynamics of Adjustment, by Herbert A. Carroll. ($6.70. Third edition. *Prentice Hall, Englewood Cliffs, New Jersey.)* The reader is informed how learning takes place, how problems are solved, and the repressions and inhibitions induced by anxiety, frustration, negativism, daydreaming. Neurotic and psychiatric adjustments are carefully explored. The author delves into the subject of getting help from the church, the school, and child guidance clinics, and examines the origin, treatment, and prevalence of juvenile delinquency.

The Recovery Room. Immediate Postoperative Management, by Max S. Sadove, M. D., and James H. Cross, M. D. ($12.00. *W. B. Saunders, Philadelphia 5, Pa.)* The authors have assembled all important data relative to the planning and function of a recovery room, as well as the medical and surgical care of the patient during the immediate postoperative period; they have carried out their purpose exceedingly well.

Clinical Selections in Dermatology and Mycology, edited by Frederick Rehm Schmidt, M. D., with 36 Specialists from various lands contributing. ($10.50. *C. C. Thomas, Springfield, Ill.)* This is a practical book for all practitioners on skin diseases and mycology infections but it also contains chapters on the diagnosis and treatment of Deficiency Skin Disorders, Collagen Diseases, Neurodermatitis, Leprosy, Tuberculosis, Leishmaniasis, Eruptive Fever, and the Malarial—so perhaps a more descriptive title would be Skin Infections and Their Background.

Soybeans for Health, Longevity and Economy, by Philip S. Chen, Ph.D. ($3.00. *The Chemical Elements, South Lancaster, Mass.)* This chemist proves that the soybean is a food without peer. It is the only vegetable food that yields a complete protein comparable in quality to that of milk, eggs, and meat. While it is doing a magnificient job in saving human beings from starvation, it is destined to play an even greater role in solving the food problem of the future as the overpopulation of the world continues to mount. Furthermore, the price is but a fraction of other protein foodstuffs.

The book gives detailed instruction on planting, fertilizing, harvesting and preserving as well as methods for making soy milk, soy cheese, soy sauce, sprouts. He has also included recipes for using soy flour, soy grits and soy flakes.

Atmospheric Pollution: Its Origin and Prevention, by A. R. Meetham, D. Sc. ($11.00. Second Edition. *Pergamon Press, Inc., London, England,* U. S. Distributors, *Pergamon Press, Inc., 122 E. 55th St., New York 22, N. Y.)* In the four years since we welcomed the first edition of this book *(Ohio State Medical Journal,* July 1954, page 654) as a comprehensive account of air pollution in the smokiest country in the world—England, much has taken place. The results of symposia and technical conferences on air pollution in both England and the United States have brought together much new information—even the International Conference on Peaceful uses of Atomic Energy at Geneva in 1955 added its share. All of these as well as the work of the several commissions have been digested and integrated into the work.

Techniques and Procedures of Anesthesia, by John Adriani, M. D. ($8.75. Second Edition. *C. C. Thomas, Springfield, Ill.)* This revision contains nine new chapters and 63 new illustrations. "The reader of this book need ask no questions." The coverage is complete.

Physical Diagnosis, by Ralph Major, M. D., and Mahlon H. Delp, M. D. ($7.00. 5th edition. *W. B. Saunders, Philadelphia 5, Pa.)* This is another revision of this standard school text and the outline of physical diagnosis.

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JONATHAN FORMAN, M. D., *Editor*

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Vancomycin Treatment in a Case of Acute Streptococcus Viridans Endocarditis

ROBERT P. KOENIG, M. D.

VANCOMYCIN,[1] a new antibiotic substance recovered from the culture media of the actinomycete, Streptomyces orientalis has proved to be bactericidal when used *in vitro* against several gram-positive cocci and spirochetes.

A CASE SUMMARY

A case of inactive rheumatic heart disease in a patient* critically ill with acute endocarditis was encountered in which the Streptococcus viridans cultured from the venous blood would not respond to therapy with streptomycin and penicillin. Because of reported *in vitro* effectiveness of vancomycin inhibiting growth of several strains of Streptococcus viridans,[3] it was suggested that this drug might be effective in this case. Of six strains of Streptoccus viridans treated *in vitro* with vancomycin four strains were inhibited.[3] No tests with Streptococcus fecalis are recorded.

This case is presented because it represents the first published case of human infection with Streptococcus viridans in which there is an early good response to treatment with vancomycin.

CASE HISTORY

This 43 year old white male who had questionable inactive rheumatic heart disease came to the hospital with a two month history of progressive weakness, fatigue and shortness of breath, which was associated with fever. He had had polyarthralgia with associated muscular pains. He had lost approximately 33 pounds weight. His past medical history was essentially negative. He had no history of rheumatic fever as a youngster. He served in the Armed Forces in World War II on active duty for better than two years without knowledge of any heart condition. About three years prior to admission murmurs were detected. Description of the previous murmurs are not available.

Submitted October 1, 1956.

*The patient was admitted to the service of Dr. W. O. Ramey, Christ Hospital, Cincinnati.

The Author

● **Dr. Koenig, Cincinnati, is a member of the courtesy staffs of Christ Hospital, Deaconess Hospital, and Bethesda Hospital; clinic instructor in diabetes, University of Cincinnati College of Medicine.**

PHYSICAL EXAMINATION

Physical examination on admission revealed a well developed, well nourished, slim, white, 43 year old male, comfortable at bed rest. The patient was "sweating" about the face. There was no cyanosis or clubbing. Several old splinter hemorrhages were seen in the nail beds. A thrill was felt in both supraclavicular fossae over the great vessels. The chest was clear.

Although the heart was enlarged clinically, the chest roentgenogram taken at the time of admission showed the heart was of normal size and the lung fields were clear. The heart beat at a normal sinus rhythm at a rate of 100. A2 was greater than P2. A Grade III systolic murmur, heard at the third left interspace and at the apex, was transmitted out toward the axilla. A very faint soft rumbling diastolic Grade I murmur was heard in this same area. The blood pressure was 120/60 in the right arm and 90/60 in the left arm blood with the patient in

the sitting position. Other physical findings were normal.

The admitting diagnosis was acute bacterial endocarditis with inactive rheumatic heart disease, probable mitral insufficiency.

COURSE IN THE HOSPITAL

Electrocardiograms taken the first week of admission showed a nodal rhythm with a rate of 100. There was tendency toward right axis deviation with normal intraventricular conduction. The conclusion was: abnormalities of a nonspecific origin. The laboratory reported during the early days of the patient's admission: Sedimentation rate, 50 mm. per hour corrected to 35 mm. per hour; red blood cell count, 4.1 million; hemoglobin, 12.6 Gm.; white blood cells, 6,500 per cubic mm.; polymorphoneuclear leukocytes, 78 with 5 per cent stab forms; 1 eosinophil; 1 basophil; 2 monocytes; 18 lymphocytes.

A blood culture taken the day of admission produced alpha hemolytic Streptococcus of the Streptococcus viridans group. The organism was not further identified. It was again cultured from venous blood two days later. Sensitivity studies with penicillin, Achromycin,® erythromycin, streptomycin, Terramycin,® Aureomycin,® and Chloromycetin® in two strengths indicated that each was ineffective. Bacitracin (20 units per disc) inhibited growth *in vitro*.

The patient was fairly comfortable at bed rest and was allowed to walk to the commode once daily. His oral temperature ranged between 100.6° and 102°. On the fourth day of hospitalization fresh splinter hemorrhages were noted in the third finger of the right hand beneath the fingernail. No other splinter hemorrhages, or petechiae were ever noted. The spleen did not enlarge. On the fifth day of hospitalization treatment with penicillin V, 250 mgm. by mouth three times daily and streptomycin 0.5 Gm. intramuscularly, two times a day was started, and continued for 18 days. Subsequent blood cultures during this admission and during subsequent admissions through the next five months produced no bacterial growth. The continuous fever spiked up and down between 100° and 102° during these days.

On the thirteenth day of hospitalization vancomycin therapy was instituted with 0.5 Gm. Vancocin® intravenously every eight hours and it was continued 12 days. Penicillin and streptomycin were continued during this time. The patient continued to deteriorate.

On the twenty-eighth hospital day the patient experienced a sudden epigastric pain which radiated into the retrosternal and left chest region. This pain was associated with severe uncontrollable nausea and vomiting. The pulse changed from a regular beat of 80 per minute to a slow, very irregular one of 58 per minute. The dull low and rumbling, diastolic murmur became much louder and was also heard at the apex. The harsh systolic murmur became higher pitched and much sharper.

The note made at the time of this episode described a critically ill patient in shock. The patient became semi-conscious and vomited severely. Shock responded poorly to oxygen, and blood pressure of 80/60 was maintained by frequent doses of Wyamine® Sulfate for about 12 hours. During this time the patient was digitalized and antibiotics were stopped. The temperature was 100.4° for about six hours.

Following this episode antimicrobial therapy was confined to vancomycin using 2 Gm. daily in a continuous intravenous drip.[2] Large doses of the antibiotic were used in this patient because of the nature of the infection. About three times as much was used in this case daily, as was proven effective in a reported case of Type III pneumococcus bronchopneumonia.

The patient began to improve slowly. Pulmonary edema was treated in the usual manner. The electrocardiogram showed a change from the previous sinus rhythm. There were frequent premature ventricular systoles, a P-R interval of 0.40 seconds, and intraventricular conduction defects. The next day the tracing showed an auricular rate of 115, a ventricular rate of 76, and a Q-R-S interval of 0.08 seconds. The A-V block continued.

The third day the auricular and ventricular rate became 68 per minute and the P-R interval was 0.36 seconds. The S-T segments which had been elevated when the patient was in shock became iso-electric. The roentgenogram of the chest showed an enlarged heart, fluid at the left base, and acute congestive changes in the lung fields. This straw-colored exudate was aspirated and was sterile when cultured.

The patient slowly responded to digitalization and frequent mercurial diuretic injections. There was a harsh, Grade III low pitched, rumbling, diastolic murmur and a high pitched, harsh, systolic murmur of equal intensity heard best at the third left interspace. The combination of these was described as "to and fro." A drip of 0.5 Gm. vancomycin three times a day or 1 gram three times daily was continued until the fifteenth hospital day and the patient remained afebrile throughout the remaining 54 days of hospitalization. When discharged, he was eating well and had no symptoms of heart failure or other complaints. When discharged, he was receiving no therapy.

READMISSION

Subsequently the patient had to be readmitted twice. At home he received mercurial injections bi-weekly to keep him free of symptoms. *He was up and about all day.* Two months after discharge he was readmitted with an acute attack of nausea, vomiting, cyanosis and dyspnea associated with pain and tenderness in the right upper abdomen. His heart revealed the same "to and fro" murmurs and there were signs of pulmonary congestion. He became icteric but this condition subsided within one week. Throughout this admission and the terminal hospitalization, congestive failure rapidly became worse with rapid development of anasarca.

He expired in congestive failure 141 days after admission for an acute illness of two months' duration.

POSTMORTEM EXAMINATION

The postmortem examination was confined to the thorax and abdomen. No septic emboli were found. No changes of toxicity were present in the liver, kidney, or other organs which could not be explained on the basis of passive hyperemia. Several petechial areas were noted in the pectoral muscles, but it is not known if these were septic.

The enlarged heart was about twice as heavy as normal. The left auricle contained a small granular thrombus. Organizing thrombi filled the right auricular appendage, interdigitating between the columnae of the right auricle and they were separated from the lumen of the chamber by a thin sheet of fibrous connective tissue. The rigid, distorted aortic cusps were partially fused to produce a small stenotic orifice. Fenestration of the non-coronary cusp produced a defect 5 by 7 mm., behind which was a 1 cm. aneurysm of the sinus of Valsalva. There were no vegetations on this or other valves. The

grossly normal mitral valve showed histologic changes compatible with healed rheumatic valvulitis.

DISCUSSION

The use of vancomycin seemed warranted in this case because the streptococcus was insensitive to other antimicrobial agents both clinically and *in vitro*. The patient showed evidence of progression of the disease while on 7.5 mg. penicillin V. and 1 gram streptomycin daily. Vancomycin is reported to be systemically a nontoxic agent useful against this group of bacteria. The sensitivity studies suggest that this organism was Streptococcus fecalis, therefore, high doses of bacteriostatic substance seemed indicated.

Acute endocarditis and particularly valvulitis as it is seen at postmortem examination is often not the cause of death. Viable organisms may be found in the characteristic vegetations at postmortem examination. It is reported that specimens in formalin may contain viable organisms after several days. Furthermore, the infection may have irreperably damaged the valve leaflets, or as occurred in this case, a foramen in one of the valves may produce irreversible physiological changes. Therefore, the total aim in therapy is not accomplished if bacterial infection is held in check.

The final picture of cure of valvulitis with endocarditis is left to the surgeon, public health doctor and perhaps to ultrasonic vibrations. This man demonstrates the ineffectiveness of therapy while controlling the infection.

The first several injections of the drug were performed with caution. At first 1.0 gram was mixed with 20 cc. of distilled water and 10 cc. of the solution injected intravenously into the larger anticubital veins. There was no change in the pulse rate or blood pressure after injection. The patient experienced no subjective change during or after injection. No subjective complaints were reported during any subsequent injection.

All injections were made by one observer at eight hour intervals for the first 12 days. The patient had an abundant supply of good veins at the start of the treatment. A flush had previously been reported to have occurred during intravenous injections, but it was not observed on any occasion during or after the injection in this patient. At first the injections were made with much caution but later the rate of injection was quite rapid. This was done in order to overcome the severe sclerosing effect of the acid bactericidal solution.

Sclerosis of veins was severe. All of the larger forearm veins were thrombosed within two weeks. It was concluded after trying many techniques that the best means to get the agent into the patient painlessly was to use a very dilute solution. When the veins were elastic and plentiful, a 5 per cent solution was injected rapidly with no ill effect. However, when smaller caliber vessels of the hand, wrist, or forearm were used there often resulted immediate pain and redness along the route of the vein. On two occasions some solution inadvertently extravasated subcutaneously. This brought immediate pain, heat, and redness to the area. In some cases this local reaction lasted as long as seven days.

Later, as good veins became more scarce, 1,000 cc. of 0.05 per cent vancomycin in 5 per cent dextrose, was given in eight hours with less sclerosis of veins. Vancocin in 0.025 per cent solution produced still less sclerosis of vessels. Smaller vessels appeared to be sclerosed more rapidly than large. The patient was maintained on anticoagulants for one month with no apparent change in the rate or degree of sclerosis.

The last method tried was to use a 12 hour drip of 0.025 per cent vancomycin in 5 per cent dextrose. No drug was administered during the next 12 hours. Thus by greatly diluting the solution less sclerosis was noted, and during the final three days of therapy, no sclerosis occurred.

SUMMARY

Vancomycin, a new antibiotic effective against gram-positive cocci was used in a case of acute Streptococcus viridans endocarditis with apparent early success. At post mortem there was no evidence of bacterial activity nor was there noted any deleterious effect of the drug. Difficulties in administration of the drug intravenously are mentioned.

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Skin Reactions to a Nicotinic Acid Ester in Tuberculosis

Skin responses to inunction with an ointment containing 5 per cent tetrahydrofurfuryl ester of nicotinic acid were observed in 166 patients hospitalized because of active tuberculosis, and were compared with those seen in 60 patients with active rheumatic fever and in 74 healthy control subjects.

In the tuberculous group, 148 patients (90.2 per cent) gave normal responses, while 16 (9.8 per cent) gave abnormal reactions; two patients gave nonreadable reactions; two patients gave nonreadable reactions. These results were in contrast to those observed in active rheumatic fever, where 87 per cent of the patients gave abnormal responses. Abnormal reactions occurred in 4.1 per cent of the healthy controls.—Milton S. Saslaw, M. D., and Murray M. Streitfeld, Ph. D., Miami: *J. Florida M. A.*, 44:152, August, 1957.

The Prognosis of Pulmonary Tuberculosis*

H. G. CURTIS, M. D.

The Author

● Dr. Curtis, Cleveland, is director of Sunny Acres, Cuyahoga County Tuberculosis Hospital.

OF the factors influencing the prognosis of a patient with pulmonary tuberculosis, probably the most significant is the presence of cavity in the lung. It carries with it the increased threat of hemoptoic or bronchogenic spread of disease, and thus may considerably impair an otherwise good prognosis. Although spread of disease may take place in the absence of cavity, its incidence is definitely increased when cavity is present.

In addition to being a source of spread of tuberculosis, the persistence of cavity or cavities favors the emergence of tubercle bacilli which are not susceptible to the antituberculosis drugs among patients receiving drug therapy. It has now been established that strains of tubercle bacilli resistant to antituberculosis agents develop more frequently in patients who have persistent cavities than in those who have none, or in those whose cavities are closed promptly under therapy.

Patients with cavities have a poorer prognosis than those without, not only for the reasons already stated, but also because they usually need longer and more drastic treatment to be cured of their disease. This group of patients requires pulmonary surgery more frequently than the noncavitary group; this by the very nature of the structures dealt with, represents very major surgery, and puts the patient at more risk than with most other kinds of operative procedures.

Occasionally, even though a patient withstands pulmonary surgery well, the postoperative complications may significantly alter his prognosis. Serious complications are fortunately not a common occurrence and ensue most frequently in patients with extensive disease who are known in advance to be poor operative risks, but who also have an even poorer prognosis for recovery without surgical intervention.

TYPE OF DISEASE

Another very important factor in determining prognosis is the type of disease present when the patient first comes under treatment. Exudative or acute tuberculosis and proliferative or chronic tuberculosis respond differently to the antituberculosis drugs. Exudative tuberculosis, before it reaches the stage of caseation, responds favorably to the drugs. Resolution occurs in most instances in a reasonable length of time, and continuing radiographic improvement is commonly seen. Positive sputum is usually converted to negative within a short period of time. Eventually there is little residue seen in the chest films.

Chronic disease, however, shows much less impressive clearing of infiltration. Progress is slow, and sputum conversion more difficult. Frequently in chronic disease the best that can be done is to prevent further progress of the disease, and to prepare the patient for surgery, if he is at all suitable. The old observation still holds good that the earlier a patient with tuberculosis is discovered and comes under treatment, the better is his prognosis.

CHOICE OF DRUGS

The proper and judicious use of the antituberculosis drugs also greatly affects prognosis. It has been shown beyond doubt that patients who are treated on a continuous drug regimen respond much more favorably than those, who through their own negligence or for some other reason, are treated intermittently. There must also be an appreciation on the part of the physician that individuals who do not close cavities within a few months may develop tubercle bacilli which are resistant to the drugs being used in their treatment. This has already been discussed. The selection of the drugs to be used, their combinations and sequence of use, must therefore be very carefully planned, particularly if it is thought that the patient will need pulmonary surgery.

Many a good prognosis has been seriously impaired by the unwise use of drugs to the point where the tubercle bacilli become resistant to all of them while the patient still remains with open, active tuberculosis. Frequently the thoughtful planning of drug therapy to include surgery at some stage in the treatment would have avoided this circumstance and could have provided an excellent prognosis.

EMOTIONAL FACTORS

Nonmedical factors also play a large part in prognosis. A patient's emotional acceptance, as well as his intellectual understanding of the fact that he has tuberculosis, is extremely important. Many patients can understand that they have tuberculosis, but they cannot accept this fact emotionally. All sorts of manifestations of

*This is one of a series of articles on chest diseases sponsored by the Ohio Trudeau Society, medical section of the Ohio Tuberculosis and Health Association.

Submitted June 18, 1957.

conscious or unconscious denial of their disease may appear. These frequently hamper all efforts to enlist the cooperation of the patient in the treatment of his disease. Many persons think that by ignoring their tuberculosis or denying its existence, they can be rid of it.

There are many other extra-medical factors of importance. Alcoholism, for instance, plays an important role in prognosis. There are many individuals who might have cured their tuberculosis, but who have eventually developed chronic and incurable disease because of their inability to handle the problem of alcoholism. Other problems connected with family and finances frequently interfere with recovery. Often the physician seems powerless to really reach the patient and influence him sufficiently to make him wish to follow the path to recovery, because too often this path requires an unusual measure of self-discipline and emotional stability. In spite of the most intensive effort on the part of doctors (including psychiatrists), nurses, social workers, clergymen, and others, it sometimes seems impossible to overcome many of the extra-medical factors which interfere with a patient's recovery.

IMPROVING THE PROGNOSIS

It would seem that to improve the prognosis of pulmonary tuberculosis, we must follow two main lines of attack. One is to constantly pursue research for new and better drugs with which to combat the tubercle bacillus; but equally important we must find new and better approaches to the patient himself. We must learn better ways to help him develop a true understanding and acceptance of his disease. We must also find better ways to help him solve or modify his psychological problems from whatever source they may stem, so that he may devote his attention and energies to curing his disease. If and when these two goals are achieved, the prognosis of all pulmonary tuberculosis will be immeasurably improved.

Urolithiasis Therapy Is Directed Toward Prevention of Stones

Citric acid, aluminum gels, sodium phytate, etc., are therapies aimed mainly at preventing crystalloid deposition. However, prevention of stones depends also on prevention of the formation of nuclei or matrix for stones.

Salicylates and small doses of cortisone acetate have been shown experimentally to cause significant reductions in the parathormone induced alteration of renal tubular collagen connective tissue matrix. Since this alteration is very possibly a prerequisite for lithogenesis, this may be a very important therapeutic method in preventing stones in all conditions. Only time and further therapeutic trial will prove or disprove this belief.—John R. Herman, M. D., New York City: *New York State J. Med.*, 57: No. 17, p. 2844, Part I, September 1, 1957.

KEEPING UP WITH MEDICINE

• RECENT work has revealed that cortisol and other anti-inflammatory hormones may be concentrated within or at the surface of the fibroblasts and this concentration is followed by a change in the structure and metabolism of the affected cell which, in turn, is correlated with a greater resistance to the processes of destruction in the inflamed area. "There is always a race between the autocatalytic cell destruction in which the breakdown of another is pitted against the inactivating of the destructive products liberated by the broken cell."

* * *

• BENZOCAINE may be the primary allergen producing the original allergic sensitivity with cross-reactions to the secondary allergens procaine, paraphenylenediamine and para-aminobenzoic acid and these relationships may be reversed so that one or the other become primary and the rest secondary.

* * *

• NUMEROUS observers have attributed to the lymphocyte chemical functions in the form either of secretion or of absorption. The secretory activities of cells, however, usually find morphologic expression in a well developed cytoplasm which is lacking in the lymphocyte.

* * *

• THE PHYSICOCHEMICAL process of the whole body buffering is an integral part of the body's response to acid-base stress.

* * *

• MANY WOMEN with premenstrual tension have either past or other present symptoms indicative of psychoneurotic patterns and are helped or relieved entirely by simple psychotherapy and mood-elevating drugs given premenstrually.

* * *

• AZO DYES which are used for many purposes and are encountered daily by millions of people, in general have a low sensitizing capacity. They are encountered every day by all of us in clothing, cosmetics, drugs, leathers, foods, beverages, and gasoline. The skin eruptions which they cause are usually the result of their role as secondary allergens. The primary allergen is more likely to be such potent related allergens as benzocaine, paraphenylenediamine, sulfonamide, etc.

* * *

• BRUCE WISEMAN was the first to analyze in detail the cellular response and to describe clearly the induction of lymphocytosis and lymphoid hyperplasia following the parenteral administration of foreign protein. This constituted a fundamental addition to our knowledge.

* * *

• INFLAMMATION occurs in interstitial tissue and does not involve directly the parenchymatous cells.—J. F.

Chronic Cardiac Compression (Constrictive Pericarditis) And Rheumatoid Arthritis; A Case Report*

Unusual Association of Two Diseases in the Same Patient

FRANK H. HEALEY, M.D., and HERSCHEL E. MOZEN, M.D.

EVER since Beck's classic descriptions of the pathologic physiology and surgical treatment of chronic cardiac compression, there has been a tremendous amount of clinical interest in this condition. This is due to the fact that the disease itself is a fascinating one and, when a proper diagnosis is made, can be cured by surgery. Recently we have studied and treated a patient with a chronically compressed heart who also had rheumatoid arthritis.

In reviewing the literature, we were struck by the extreme rarity of this particular association. In fact, only one other case was found in which both of these diseases were present.[4] In 72 cases of chronic cardiac compression in which operation was performed by Dr. Claude S. Beck, the associated occurrence of rheumatoid arthritis was never noted.[3] We feel that our case should be reported because of the rarity of this combination.[1] In addition, the possibility of a common etiologic factor should be considered.

CASE REPORT

The patient is a 48 year old white male. He was first admitted to this hospital on June 25, 1954. The diagnosis of rheumatoid arthritis was made 16 years ago. Four years prior to admission, he had a six week episode of fever, malaise, fatigue and swelling of the knee joints. A diagnosis of acute rheumatic fever was made. The illness responded moderately well to bed rest and salicylates.

Beginning 10 months prior to admission, he noted progressive fatigue and dyspnea on exertion. Four months prior to admission, he began to have a dull, aching anterior chest pain. An electrocardiogram taken at that time was normal. The pain persisted for several weeks, until he was awakened one night by a very severe pain which originated in the back of his head and radiated to both shoulders and arms. A spiking fever was also noted. He was hospitalized, treated with digitalis and antibiotics, and discharged with the diagnosis of Pick's syndrome.

His symptoms persisted. They were controlled by digitalis and mercurial diuretics. Seven weeks prior to admission here, he was again hospitalized. This time there was no improvement. His condition remained essentially unchanged up to the time of admission to this hospital. He lost 40 to 45 pounds during the past year. There is no family or past history of tuberculosis. He denied a history of pneumonia, cough or hemoptysis.

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On physical examination, the patient appeared chronically and seriously ill. There was moderate cervical venous engorgement. There were signs of fluid at the right base, posteriorly. Precordial activity was minimal. The heart was not enlarged. Heart sounds were diminished in intensity and there were no murmurs. The liver edge was palpable 3 fingerbreadths below the right costal margin and was non-tender. There was characteristic rheumatoid deformity of the wrists, knees and proximal interphalangeal joints of the fingers. Fluid was present in both knee joints. There was generalized atrophy of soft tissues, most marked in the extremities.

The hospital course was characterized by a spiking fever which ranged from 37° to 39°C. The fever was accompanied by marked diaphoresis. The knee joints were aspirated and injected with compound F with moderate relief of symptoms.

There was x-ray evidence of rheumatoid and osteoarthritic changes in all the major joints. Cardiac fluoroscopy revealed an inactive heart of normal size. Hemograms and urinalysis were normal. Sedimentation rates were consistently elevated to 32 to 34 mm. per hour. Serum sodium, potassium and chloride levels as well as total proteins were normal. Blood urea nitrogen and bromsulfalein retention were also within normal limits. Vital capacity was 2.4 liters. Venous pressures, on three separate determinations, were 13.0, 12.5, and 13.0 cm. of saline. Circulation time (A-T) was 27 seconds. Blood cultures and acid-fast smears of gastric washings and joint fluid were all negative. Second strength purified protein derivative tuberculin test was positive in 48 hours.

A diagnosis of "pre-ascitic" chronic cardiac compression was made. This means that although a compression scar was already present on the heart, it was still relatively elastic and distensible. The venous pressure elevation had not

yet reached the level at which fluid leaves the vascular bed to accumulate in the tissues. Beck has demonstrated this level to be approximately 20.0 centimeters of saline.[2] During this admission, there was evidence of an active inflammatory process in the joints. There was also a question of possible active pericarditis. No operation was advised and the patient was discharged to the care of his local physician.

He was readmitted to University Hospitals on March 21, 1955, after an interval of eight and one-half months. During this period there was evident progression of the disease with the appearance of ascites, edema, and markedly increased fatigue and dyspnea on exertion. This increase in clinical symptoms was due to further compression of the heart by contraction of the previously elastic pericardial scar. In addition, there was also increasing disability from his arthritic joints.

During this second admission, the essential physical findings were: a small quiet heart, marked venous engorgement, a large tender liver, ascites, generalized edema and diffuse dependent cyanosis. Pulsus paradoxus was also present. Besides the previously noted joint changes, numerous soft subcutaneous nodules were observed on the extensor surface of the left forearm. Fluoroscopy revealed a straightening of both the right and left borders of the cardiac silhouette. The heart pulsated even less vigorously than during the previous examination. There was no pericardial calcification.

Sedimentation rates were moderately elevated to 23 to 27 mm. per hour. There was reversal of the A/G ratio with total proteins of 6.9 gm. per 100 ml., albumin of 3.4 and globulin of 3.5. There was marked elevation of the venous pressure to 27.0 and 31.0 cm. of saline on two separate determinations. This increase in venous pressure indicated that the compression of the heart had progressed from the "pre-ascitic" stage to the stage of frank fluid accumulation. Circulation time was still prolonged. Vital capacity was further reduced to 1.3 liters. L-E blood smear preparations were negative. A lymph node was biopsied and was reported as showing "reactive hyperplasia." Cardiac catheterization was performed with the characteristic findings of chronic cardiac compression. The pressures were as follows:

Right Main Pulmonary Artery	43/26 (35)
Main Pulmonary Artery	45/22-52/26 (38)
Low Right Ventricle	42/22-25/22 (28)
Low Right Atrium	28/22-30/20 (21)
High Right Atrium	22/20-27/23 (21)

There was moderate right ventricular and right atrial hypertension. In addition, an early diastolic dip and endiastolic plateau in the ventricular tracings, as well as M and W shaped atrial tracings were observed. A paradoxical pulse was recorded within the right ventricle.

Operation was performed on March 31, 1955, by Dr. Claude S. Beck. The entire heart was encased in a fibrous pericardial scar which averaged 0.5 to 0.8 cm. in thickness. All of the anterior and lateral aspects of the heart, including the venae cavae and bases of the aorta and pulmonary artery, were freed from the scar. The heart promptly began to fill better and had a much stronger pulsation. There was no evidence of active pericardial or mediastinal infection at the time of surgery. The pathologic diagnosis on the surgical specimen was "acute fibrinous and chronic fibrous pericarditis." Direct acid-fast smears of this material were negative.

The immediate postoperative results were dramatic. The pulse pressure promptly increased. There was a marked spontaneous diuresis with weight loss and disappearance of ascites and edema. The patient's general outlook and sense of well-being was greatly improved. An unusual and unexplained result was the marked decrease in joint pain and stiffness. In fact, this previously bed-ridden patient was able to get out of bed by himself and take a few steps at the time of discharge, 16 days after surgery. Postoperative x-rays and fluoroscopy revealed great improvement in cardiac pulsations. Venous pressure after operation was 15.0 cm. of saline, and will no doubt continue to decline to a completely normal level.

DISCUSSION

The etiology of chronic cardiac compression is often quite obscure. Most authors regard tuberculosis as the single most frequent causative agent. Frequently we must accept a tuberculosis basis for this disease even when the tubercle bacillus is not specifically isolated. A certain percentage of patients give a history of acute rheumatic fever and may exhibit recurrent episodes of the "rheumatic state." However, no one has yet defined a clear-cut relationship between rheumatic fever and chronic cardiac compression. Various other causes of the pericardial scar which have been considered are: pyogenic pericarditis, hemopericardium, pneumonia, tularemia, metastatic carcinoma and nonspecific febrile illnesses. And of course, a certain number of cases are labelled idiopathic.

The extremely unusual occurrence of chronic cardiac compression in a patient with rheumatoid arthritis raises the question of an additional etiologic factor. The possibility of a collagen-disease basis for both of these diseases is considered, although we have no confirmatory evidence. Perhaps future reports will help to clarify the cause of the large number of cases which at present are considered idiopathic.

SUMMARY

The occurrence of the two diseases, chronic cardiac compression and rheumatoid arthritis, in the same patient is very rare. A case of such an unusual association is presented. Etiologic factors are discussed and the possibility of a common basis for the two diseases is considered.

Acknowledgment: Grateful acknowledgment is made to Dr. Claude S. Beck for permission to report on his patient as well as for access to his personal operative records; and to Dr. Harold Feil for his assistance and stimulating criticism in the preparation of this report.

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False Aneurysm of the Facial Artery: Case Report And Review of Literature

J. W. SAMPSEL, M. D., and C. W. HOLCOMB, M. D.

LACERATIONS of major arteries frequently give rise to spurious aneurysms. These lesions usually follow extensive trauma or penetration of high velocity missiles in the vicinity of major vessels. The brachial, axillary and popliteal vessels are most frequently involved, and the defects are usually large pulsating masses.[1] It is difficult to see how an aneurysm could develop from trauma to the small facial artery. However, when conditions are right, such a lesion can form from insignificant injury and become a threat to life. It is the object of this report to present this rare complication of a simple face laceration. Petitti and Jennings recorded a similar case in a battle casualty from the Korean War.[2]

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CASE REPORT

Complaint: "Bleeding and cut face."

Present Illness: A 6 year old boy was admitted to Memorial Hospital of Union County from his physician's office; his parent held a gauze pad over a wound on the left cheek. Ten days before admission he was bumped while playing and sustained a small through-and-through laceration when a tooth was forced through the cheek just lateral to the angle of the mouth. The external wound was smaller than one centimeter. Bleeding was profuse at first. Two sutures were applied externally to close the skin wound and these were removed five days later. On the day of admission he was examined by another physician for fever and cough. Swelling and erythema had developed at the site of the laceration. The external surface of the wound was not probed but a small superficial crust was removed and dramatic hemorrhage followed. Blood was under considerable pressure and it spurted about two feet from the wound. Direct pressure was applied and this curtailed the bleeding.

Past History, Family History: Noncontributory.

Examination: Temperature 102.4°; pulse 130; respirations 40. The patient was a well developed, well nourished, pale child of 6 years with blood-stained clothing. The gauze dressing was removed from the face and bleeding had subsided. The lesion presented as a three centimeter diameter rounded cystic mass on the left cheek (Fig. 1 and Fig. 2) just lateral to the left angle of the month. It was best palpated bimanually with one finger on the mucosal surface of the cheek and the other externally placed.

The mass protruded externally, but also extended into the mouth. It pulsated and expanded in every direction with each pulsation. There was a small ulceration approximately one half centimeter in diameter over the summit of the mass, and pulsation was especially evident in the base of this ulceration.

The general physical examination showed only extensive rales and rhonchi. These were most prominent in the left base.

Laboratory and X-Ray Findings: White blood cell count 17,700; red blood cell count 3,900,000; hemoglobin 60 per cent; urine examination was normal; chest plate showed equivocal prominence of the right auricle.

Subsequent Course: The child was admitted and observed. It did not appear that he would cooperate to undergo excision of the pulsating mass under local anesthetic, and it was hazardous to attempt endotracheal anesthesia in the presence of the severe bronchitis. The face lesion was covered with a pressure dressing and attention was directed to treating the bronchitis. Tetracycline, then erythromycin, nose drops, expectorants, and steam inhalations were used, but the rales and rhonchi persisted at the left base.

The lesion showed no further sign of bleeding and a firm crust had formed over the surface. There was evidence of skin regeneration at the edges of the superficial ulcer. The temperature was still 101° after five days in the hospital. The patient was coughing and bringing up large quantities of mucus. It was elected to send the child home for further antibiotic therapy before exposing him to endotracheal anesthesia. The pulsating mass was unchanged save for evidence of healing over the superficial erosion. It was planned to re-admit him for elective excision when the bronchitis had cleared.

Three days after discharge another massive hemorrhage was suddenly started at home when the child bumped the cheek lesion with his knee. The parents came to the hospital with pressure over the lesion. Once again, bleeding had stopped when he arrived, but the child was pale, had blood all over his clothing, and the pulse was rapid. The bronchitis was still a problem with cough and fever. It appeared that the mass had increased in size slightly. It was decided to at-

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tempt excision under local anesthesia with heavy sedation. 250 cc. of whole blood were given before surgery.

Operation: The patient was heavily pre-medicated with Demerol® and scopolamine before coming to the operating room. Anesthesia was provided by a block of the infra-orbital and mental nerves on left. The initial incision was made over the lesion and it paralleled the left naso-labial fold and extended to the chin. An attempt was made to isolate the external maxillary artery beneath the mass, but no artery was found at first, and dissection was carried out superiorly and inferiorly around the lesion.



Fig. 1. Photograph of left cheek before operation showing the raised pulsating mass and central ulceration. The slight surrounding redness and the clot at base of ulceration would easily make one suspect only hematoma if the mass were not palpated for pulsation.



Fig. 2. Lateral view of lesion to show the extent to which it protruded from the cheek. It also extended within the mouth to lesser degree.



Fig. 3. Photograph of gross specimen showing fibrous walls of false sac and smooth inner cavity that communicated with small facial artery.

The dark, reddish brown, pulsating mass was gradually exposed, and fibrous tissue was arranged around it in layers. Pulsations in the vessel feeding the aneurysm were palpated with one finger in the mouth. Attempts were being made to elevate the inferior lateral aspect of the aneurysm to expose the feeding vessel when there resulted a sudden spurt of blood from the laminated thrombus, and the entire aneurysm came away from its bed.

A small artery was identified in the floor of this cavity and a 2 millimeter nick in its medial anterior wall was actively bleeding. It was approximately in the region of the external maxillary bifurcation into inferior and superior labial vessels, and the angular artery bifurcated at this point also. The nick was rather deep within the substance of the facial muscles. The vessels proximal and distal to the small laceration were clamped with mosquito hemostats and tied with suture ligatures at this location. No branches of the facial nerve were identified. The skin wound was approximately 4 centimeters long. It was closed with 3-0 plain to deep structures and 5-0 silk to skin.

The postoperative course was without incident. The wound healed well and there was minimal facial scar with little underlying induration.

Pathology: The lesion was 2.5 centimeters in diameter, round, firm, reddish brown on the external surface. It contained a central smooth cavity approximately 1.5 centimeters in diameter and the walls were 5 millimeters in thickness (Fig. 3).

Microscopic section of the walls showed organized and recent thrombus.

DISCUSSION

Small arteries of the face known to be the site of false aneurysm formation are the superficial temporal and the external maxillary or facial. The lesion has been much more frequent in the former vessel[3, 4] because of its longer course in a relatively superficial and accessible position, and a high percentage of these lesions have been arteriovenous fistulae. The latter arteriovenous communication has also been recorded following the application of a pin to the mandible, and the vessel injury occurred in the external maxillary artery in its course over the body of this bone.[5] The previously recorded case of aneurysm in the facial artery occurred at the terminal portion of the external maxillary where it continues as the angular artery to the edge of the nose.[2] This also appears to be the exact site of the lesion in the present instance.

ANATOMY

It is of significance that the external maxillary artery and its branches are submucosal in this location. The vessel springs from the external carotid,[6] appears at the base of the jaw immediately in front of the masseter muscle, and passes upward in a tortuous manner toward the angle of the mouth. In its lower part, the

artery rests on the mandible and is covered only by skin and risorius muscle. Above the mandible it travels on the surface of the buccinator and a little higher is crossed by the zygomaticus major muscle. Small branches of the facial nerve to the orbicularis oris are superficial to it. Just opposite the angle of the mouth it is separated from the mucosa of the cheek by the fat pad of Bichat, and the parotid duct opening is just beneath it.

ETIOLOGY

The submucosal position of the prominent facial vessel at the angle of the mouth makes it prone to injury from within. Frequently when trauma to the cheek and lips forces a tooth through the mucosa, the vessel is probably completely severed and bleeding follows with the formation of a hematoma within the substance of the cheek, but the vessel retracts and its lumen becomes plugged with clot. To explain the formation of this false aneurysm, one would have to assume a partial laceration of the vessel wall or a laceration-contusion with secondary breakdown in the artery wall and the formation of a hematoma that communciates with the arterial lumen. It is probable that the aneurysm develops by the pounding of the pulsating stream in the solid plugging hematoma clot.[7] The periphery of the mass organizes and the central portion becomes hollowed out by the force of the pulsating stream. It appears that the pressure reaches high values in this pulsating hematoma. The walls become fibrous and the inner cavity may be endothelial covered. If allowed to persist long enough it is readily seen how much such a lesion would slowly enlarge and produce complications by rupture with massive hemorrhage, cause pressure on adjacent structures and produce pain, deformity, or unsightly swelling and become annoying to the patient when he feels the pulsating mass.

DIAGNOSIS

The major pitfall in the diagnosis has been mistaking the pulsating hematoma for abscess or simple hematoma. Thus the lesion may be opened with great surprise to the operator when he is greeted by the gush of blood. Or, worse yet, would be to observe these lesions until spontaneous rupture would take place with possible death from immediate hemorrhage. Many false aneurysms in other regions[8] have been so opened and in the present case removing the small dry covering over the sac resulted in major alarming hemorrhage.

It is to be noted that not all small peripheral lesions have shown prominent pulsations. In some the pulsation is slight or absent. It is conceivable that the swelling on the face might also be mistaken for a sebaceous cyst with infection or cavernous hemangioma. It is wise to consider pulsating hamatoma or false aneurysm in any mass that presents after trauma, to examine the mass carefully for bruit and check to see if proximal compressions of the artery reduces pulsation. The lesion should be aspirated with a small needle before incision is made.

TREATMENT

There can be no question but that the lesions should be removed when discovered. The definitive surgical therapy is simple when compared to its counterpart in a major vessel. There is no problem with peripheral ischemia and collateral circulation is excellent about the face. Proximal and distal control of the small external maxillary artery was obtained by use of rubbershod clamps in the preceding case,[2] but it appears to be a relatively simple maneuver to obtain control of this small vessel by pressure with fingers of the assistant during excision. This appeared to be readily accomplished by placing one digit within the mouth and compressing the vessel between this and one externally placed.

Also, it is interesting to note how easily the aneurysmal sac was dissected from the surrounding tissue of the cheek by blunt methods when the proper plane was entered around the fibrous wall. Pressure on the mass from within the mouth seemed to help delineate the mass for this dissection. It may be wise to obtain control of the external maxillary artery at the angle of the jaw before attempting excision of such a lesion, especially if the artery can readily be palpated here and if compression would reduce the pulsation in the mass. A small nick could be made and blunt dissection used to place a ligature about the feeding vessel.

The mandibular branch of the facial nerve should be avoided by blunt dissection and the small scar could be placed beneath the chin so as to not be prominent. The small facial artery could then be ligated in the vicinity of the sac before or after the latter is removed. On the face, attention should be given to the cosmetic result, and the elliptical incision should be made parallel to the skin lines. It should be remembered that small branches of facial nerve need be avoided and preserved in the dissection.

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Prolonged Pregnancy

H. F. BURKONS, M.D.

THE matter of pregnancy that has continued for days or weeks past the usually accepted average duration has engendered in both obstetrician and patient a feeling of concern and often outright alarm. As time passes without the expected onset of labor the thought that something tragic might happen to the presently living fetus becomes more and more pressing. Uneasy doubts assail the psyche of the accoucheur. Will the baby die in utero during this "do nothing" period? Or, when labor does finally develop will the baby be oversize for the term-size maternal pelvis? Or, will the seeming unwillingness of the uterine musculature to initiate labor be carried over to incoordinate uterine inertia?

Then add the sometimes vocal concern of the patient and family to that of the obstetrician and the insistent question of the moment is, *What to do?* Most recent writers on this subject feel that prolonged pregnancy leading to postmaturity is a real pathological condition. A lesser number honestly feel that there is much ado about nothing.

Over the years it has become accepted that the period of human gestation averages about 280 days from the first day of the last menstrual period in the case of the rhythmically menstruating woman. Common usage states that her pregnancy is prolonged if it continues past 295 days. In the instance of the arrhythmical individual with menstrual interval varying widely, the determination of full term and prolonged pregnancy become difficult of comprehension and thus should not be included in any serious consideration of this topic.

REASON FOR INVESTIGATION

Few subjects present a greater variance of opinion—often diametrically opposite—than that of prolonged pregnancy.

In the June, 1955, issue of *Obstetrical and Gynecological Survey*, Robert E. L. Nesbitt, Jr.,[1] presents a masterful review of 416 articles relating to prolonged pregnancy. Careful perusal of this comprehensive article leaves one with a feeling of indecision regarding almost every facet of this obstetrical subject ranging from whether or not postmaturity exists, whether or not there is a diminution of oxygen saturation of cord blood as pregnancy progresses beyond term, whether or not the placenta demonstrates pathological findings, whether or not labor should be induced, etc.

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Submitted October 8, 1956.

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Reliable investigators are arrayed on each side of each controversial problem. In view of the cacophony of opinion it seemed appropriate to carefully inspect the results of untreated prolonged pregnancy at Saint Luke's Hospital to evaluate the presence or absence of real danger.

The present study of prolonged pregnancy was instituted about a year ago after it was found that the obtaining of information in regard to this subject from the records was not entirely satisfactory since some of the items of importance to a survey of prolonged pregnancy were not routinely recorded. In order to secure data of a reliable nature which could then be used for easy statistical analysis a specially prepared "prolonged pregnancy sheet" was attached to the routine chart. This was filled out at the time of admission and following delivery of the patient, and following discharge of the baby, with special attention paid to the recording of the fetal and maternal items important in the study of prolonged pregnancy.

During the 13 months from August, 1954, through August, 1955, a total of 3,383 deliveries occurred at Saint Luke's Hospital. Of this number, 2,600 survey sheets were complete enough to be used and included only the regularly menstruating parturients.

A total of 159 pregnancies, or 6.1 per cent, were registered as prolonged, i. e. were more than 295 days since the last normal menstrual period occurring in women whose menstrual cycles were usually of 28-31 days' duration. The individuals whose periods were grossly irregular were eliminated from this figure of 159 cases.

PROLONGED PREGNANCY—PHYSIOLOGICAL AND PATHOLOGICAL

The prolonged pregnancies were divided into physiologic and pathologic categories (table 1). Physiologic, where there was no apparent aberration in regard to the pregnancy, labor, delivery or fate of the fetus. The pathologic group contained the cases where the so-called postmature syndrome existed; consisting of meconium-stained amniotic fluid, meconium-stained umbilical cord and placenta, staining of the fetal epidermis and

nails, wrinkling and desquamation of the skin. Not all of these features were present in each case.

TABLE 1.—PROLONGED PREGNANCY

Physiologic	142	89.3%
Pathologic	17	10.7%
Total	159	

FETAL MORTALITY

The total fetal mortality in this series consisted of 2 deaths (1.26 per cent)—one stillborn and one neonatal, both of which occurred in the pathologic group. In the case of the stillborn fetus there was question of cord compression rather than postmaturity as the etiological factor.

It is interesting to compare the fetal mortality rate in the prolonged pregnancy group due to possible postmaturity and the rate among term births where death is of unknown etiology (eliminating deaths due to placenta ablatio, eclampsia, anomalies, etc.)—table 2. We see that there is a difference of possible significance. In the prolonged pregnancy group the fetal mortality rate is 65 per cent greater than in the term group, i. e. 1.26 to 0.82 per cent. These figures point up the fact that the prolonged pregnancy patient has a greater potential for danger as far as the fetus is concerned than does the term patient.

TABLE 2.—FETAL MORTALITY

	Total Births	Number Deaths	%
Saint Luke's Hospital (1954)	3,022 (viable)	79*	2.61
Prolonged pregnancy group	159	2	1.26
Fetal deaths at term of unknown etiology (1954)	2,654**	22	0.82

*Includes all deaths for any reason.

**(3,022, less 368 consisting of premature living 108, premature dead 22, stillbirths over viability 43 [cause unknown], neonatal deaths over viability 36, prolonged pregnancy cases 159.)

AGE AND PARITY

The age and parity of the prolonged pregnancy patient varies in about the same degree as in pregnancy at large.

TABLE 3.—AGE OF PROLONGED PREGNANCY PATIENT

Age	Physiological	Pathological
15-20	19	0
21-25	47	5
26-30	34	8
31-35	23	4
36-40	14	0
41-45	2	0
46-50	1	0

TABLE 4.—PARITY OF PROLONGED PREGNANCY PATIENT

	Primipara	Multipara
Physiological	44 (31%)	98 (69%)
Pathological	6 (35%)	11 (65%)

In a recent survey of 1,000 consecutive obstetric patients, published by the author of the present article, the ratio of primipara and multipara was almost exactly the same, i. e. 32 to 68 per cent.[2] Thus prolonged pregnancy has no special affinity for either primipara or multipara.

LENGTH OF LABOR

A number of the articles reviewed seemed to indicate that uterine inertia due to incoordinate contractions is more prevalent in the prolonged pregnancy case than in the term individual.

The experience in this series is detailed in table 5.

TABLE 5.—LENGTH OF LABOR

	Total		Physiologic (Hours)	Pathologic
Pentad I	75	P	11½	
(295-299 days)		M	6½	
Pentad II	42	P	8½	Not significant because of too few cases
(300-304 days)		M	7½	
Pentad III	14	P	8¾	
(305-309 days)		M	6	
Pentad IV	11	P	3	
(310-314 days)		M	4	
Total average	142	P	10½	14¾
		M	6½	4¾

Most authorities state that the average duration of the primiparous labor is 16 to 18 hours and that of the multipara is 10 to 12 hours. These given figures include mostly spontaneous deliveries, whereas our present series of labors were in the main terminated by forceps, thus shortening the labor somewhat. Nevertheless it is apparent that the prolonged pregnancy labors in this series certainly were not extended beyond the average.

Oddly enough, it appears that the labor becomes more rapid the longer the prolongation of pregnancy—Pentad IV showing the shortest labor.

METHOD OF DELIVERY

In table 6 there is a detailed presentation of the methods of delivery used in the physiologic and pathologic prolonged pregnancy cases, and for comparison, the values found in the series of 1,000 consecutive obstetric patients mentioned previously. The percentage difference between the three categories vary so little that for all practical purposes they are about the same. Therefore, it seems that the prolonged pregnancy deliveries involved no greater effort than that required in a series of consecutive deliveries.

WEIGHT OF BABY

In many instances prolonged pregnancy engenders the fear of an overweight baby. Table 7 gives the pertinent information in this regard. Eastman[3] states that the average weight of the white newborn baby is about 7 pounds. In table 7 we can see that the average weight in this prolonged pregnancy series is somewhat larger than

TABLE 6.—METHOD OF DELIVERY

	Physiologic			Pathologic			Consecutive Series
	Primip.	Multip.	Total	Primip.	Multip.	Total	Total %
Spontaneous	0	25	12.5%	0	3	17.7%	13.4%
Low forceps	33	68	71.1%	6	7	76.5%	75.7%
Mid forceps	7	1	5.6%	0	0	0	4.6%
Breech ext.	2	2	2.8%	0	1	5.9%	3.6%
Ces. Section	2	0	1.4%	0	0	0	2.7%
Other	0	2*	1.4%	0	0	0	0

*1 podalic version; 1 face presentation

TABLE 7.—WEIGHT OF BABY

	To-tal	5 to 5-15	6 to 6-15	7 to 7-15	8 to 8-15	9 to 9-15	10 to 10-15	11 to 11-15	Average
Pentad I 295-299 days	75	3	23	25	13	10	1	0	7 lbs. 10 oz.
Pentad II 300-304 days	42	1	5	18	11	3	2	2	7 " 15 "
Pentad III 305-309 days	14	0	5	7	1	1	0	0	7 " 5 "
Pentad IV 310-314 days	11	1	3	4	3	0	0	0	7 " 3 "
Pathologic 295-309 days	17	1	4	5	5	1	0	1	8 " —

what is considered the median normal weight of the newborn.

This is an item that must be considered in the overall picture. Will the larger baby in prolonged pregnancy produce dystocia because of its size? And would it be best to prevent this increase in size by inducing labor earlier? This matter will be discussed later bearing in mind that the most experienced obstetrician is hard put to accurately estimate fetal weight. The roentgenologist in this regard can only offer an approximation.

DELAY IN FETAL RESPIRATION

As an indication of the initial well-being of the newly born infant we have indicated in table 8 the delay in respiration following the birth of the baby. The analgesic used in most cases was Demerol® and scopolamine with low spinal anesthesia. For comparative information there is also presented the respiration delay found in the previously mentioned survey of 1,000 consecutive obstetric patients.

TABLE 8.—DELAY IN RESPIRATION

	Physiologic (142)		Pathologic (16) Less 1 stillborn		Consecutive Series (800)	
No delay	128	(90.1%)	11	(68.7%)	715	(89.3%)
1 minute	3	(2.1%)	1	(6.3%)	17	(2.2%)
2 minutes	3	(2.1%)	0		30	(3.7%)
3 minutes	3	(2.1%)	3	(18.7%)	21	(2.7%)
4 minutes	2	(1.4%)	1	(6.3%)	14	(1.8%)
5 minutes	2	(1.4%)	0		3	(0.3%)
8 minutes	1	(0.8%)	0		0	

The delay in respiration in the physiologic and consecutive series groups is about the same, while the delay in the pathologic group is somewhat more marked. Apparently from this evidence we can say that prolonged pregnancy does not markedly jeopardize the initial respiration of the newborn as compared with the term baby.

MANAGEMENT OF THE PROLONGED PREGNANCY

From the data presented in this article, prolonged pregnancy may on occasion be a threat to the welfare of the unborn or newborn fetus.

In discussing the conduct of a case of prolonged pregnancy, two main points must be borne in mind. (1) The physiologic or benign type comprises the majority of prolonged pregnancy cases (89.3 per cent), while the pathologic type occurs infrequently (10.7 per cent), and of this number only a relatively few are actually life-threatening. At present there is no pre-delivery method of effectively diagnosing the one type from the other.

(2) The obstetrician must be aware of the fact that the only known treatment of prolonged pregnancy, which is induction of labor near term, can be a hazardous procedure and thus may pose a greater threat to the life of the fetus than the prolonged pregnancy itself.

In formulating a course of action one must always take into account, and weigh in the balance, the advantages and disadvantages of the available procedures.

Since it has been determined that prolonged pregnancy has a pathological component of postmaturity it is obvious then that the prevention of increased fetal weight and increased fetal mortality could be avoided by induction of labor soon after term. Logically this procedure should lessen the danger to the fetus.

What is the disadvantage or risk of induction? First of all, medical induction consisting of castor oil, enemas, hot baths, etc., is usually unsuccessful. The surgical induction by means of amniot-

omy with or without posterior pituitary extract is successful when it works, as it does in most properly selected cases. However, when it fails it can dangerously embarrass the fetus because of uterine inertia leading to long, exhausting, slowly advancing labor followed perhaps by a complicated delivery which may necessarily include cervicotomy due to failure of dilatation and traumatic mid forceps delivery.

Also, thought must be given to the risk of prolapsed cord which occurs on occasion following artificial rupture of membranes. Or if a cesarean section is elected this imposes an added burden on the mother, with the prospect of future deliveries by the same route, plus the additional fact that an otherwise normal term baby may do poorly when ushered into the world via cesarean section.

Any obstetrician of experience will bear out the risk of incoordinate, sluggish labor following artificial induction when the uterus in its own stubborn way declines to be induced.

SPECIFIC RECOMMENDATIONS

Therefore, following are my recommendations for handling the prolonged pregnancy patient:

(1) The obstetrician can accept a small calculated risk and with comparative safety permit the patient to continue pregnancy until labor naturally ensues rather than expose her to the hazards of the vaginal route induction of labor or cesarean section.

(2) If the obstetrician is inclined to interfere because of fear of postmaturity he can and should do so *providing* the patient is ripe for induction, i. e. vertex presenting well into pelvis, cervix almost entirely effaced and dilated 1 to 2 cm. The method of induction should consist of amniotomy and if necessary intramuscular Pitocin® starting with 0.5 minim and increasing by 0.5 minim each 30 minutes until 2 minims is exhibited. Intravenous Pitocin drip may be used.

(3) If the cervix is uneffaced, i. e. not ripe for induction, the procedure should consist of confident reassurance to the patient. Office visits every five days are advisable at which time rectal or sterile vaginal examination should be done in order to determine if induction has become feasible.

(4) If the baby appears to be increasing in size unduly, nothing other than what has been advised previously need be done. Of course, when labor does develop, naturally or by induction, careful observation, clinical and by x-ray, should be used to determine the presence of disproportion. If disproportion does exist it should be treated just as in the term pregnancy.

Although the average prolonged pregnancy newborn seems to be somewhat larger than the average term baby the difference is not sufficient to offer routine concern.

(5) Cesarean section is not justified or necessary in the management of obstetrically uncomplicated prolonged pregnancy. However, an exception can be made where the individual is an elderly primipara with an extra-valuable baby.

(6) In order to minimize respiratory embarrassment in the event that the unborn or newborn fetus should turn out to be of the pathological variety, it is best to exhibit a lesser amount of analgesia during labor and to use low spinal or local pudendal block anesthesia for the delivery.

(7) The pediatric management in the approximately 11 per cent pathologic prolonged pregnancy cases should be promptly instituted. This consists of incubator warmth with proper oxygen administration and the use of humidity.

SUMMARY

Now to summarize briefly:

(1) Out of 2,600 pregnancies, 159 (or 6.1 per cent) were prolonged beyond 295 days.

(2) Of the 159 cases 89 per cent were physiological and 11 per cent were pathological.

(3) The fetal mortality consisted of two babies, or 1.26 per cent.

(4) Age and parity of the prolonged pregnancy patient were not remarkable.

(5) Length of labor was found to be about the same or even less than a control series.

(6) Method of delivery differed little from a control series.

(7) Weight of the baby averaged somewhat greater than the usually accepted weight.

(8) Delay in initial respiration was not prolonged above that found in a control series.

(9) Management is recommended as follows:

a. Since 90 per cent of cases are benign a policy of watchful observation is adequate treatment.

b. If cervix ripe for induction, amniotomy can and should be done.

c. If the cervix is uneffaced, continue waiting with frequent check of condition of cervix.

d. Cesarean section not justified unless for obstetrical indications or elderly primipara with extra-valuable baby.

e. Use less analgesia and low spinal anesthesia in prolonged pregnancy to minimize respiratory embarrassment in event child should be of pathological type.

f. Immediately after birth, if pathological variety, use incubator with oxygen and humidity.

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Clinical Evaluation of a Combination of Hydrocortisone And Crotonyl-N-Ethyl-O-Toluidine (Eurax®) For Topical Therapy

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INTRODUCTION

THE earlier works of Goldman et al.,[1] and of Sulzberger and Witten[2] showed that the corticosteroids were capable of local action by topical application, as well as by their use systemically. Hydrocortisone, and many of its analogs, such as: fluorohydrocortisone, fludrohydrocortisone, prednisolone, etc., soon found widespread use in a huge variety of commercially available ointments, lotions, creams, etc. In many instances these topical steroids proved disappointing, since they were used on a purely empirical basis, and without regard for their pharmacodynamic action.

Experience and investigation have not as yet entirely established their full pharmacodynamic activity, but their major known action is their ability to inhibit inflammation. Possibly too, they may alter the electrolytic balances of the tissues. From this knowledge certain more definite facts concerning the topical use of the corticosteroids have evolved.

CLINICAL CONSIDERATIONS IN TOPICAL STEROID THERAPY

The dermatological conditions most effectively treated by means of the topical steroids are those in which local irritation, eczematization, allergic reactions, localized edema, etc., predominate the objective findings of the clinical picture. Conversely, these topical steroids are much less valuable when lichenification, trophic changes, scarring, deep induration or similar circumstances play the major role.

Reduction of inflammation, while no doubt of great value in any given case, may well alter the objective picture without any benefit from a subjective viewpoint. Goldman[3] states, "Originally everybody supposed that the relief of inflammation would relieve pruritus. This, however, does not always happen." The topical steroids have no inherent antipruritic action, and neither does suppression of inflammation always result in cure. Flares while under such therapy, and recurrences following withdrawal are not uncommonly seen.

The antiphlogestic action of these preparations results in a decrease of immunity to infection by reducing the migration of blood elements to the site of injury. This is especially true of bacterial infection, but is also true of fungal or viral infection. Hence such topical steroid therapy may well encourage or mask infection. It has become common practice to incorporate some bactericidal agent—usually one of the so-called "wide spectrum" antibiotics into the steroid medicaments in an effort to overcome this tendency towards infection. To a fair degree, this has been successful, but is still not ideal for a number of reasons.

Materials for this study were supplied by Geigy Pharmaceuticals, Inc., Yonkers, N. Y.
Submitted October 25, 1956.

The Author

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HYDROCORTISONE AND ANTIBIOTIC COMBINATIONS FOR TOPICAL USE

The antibiotics, like the corticosteroids, are not in themselves antipruritic agents. Such help for this purpose as is seemingly derived from their use may well be due to the action of the vehicle used, or to the relief of local irritation from the infectious processes, or even to psychic factors. Again, it seems that the bacteria often develop tolerance to these topically applied antibiotics after a certain time interval. This may be due to actually developing resistant strains, to the decrease of competition from weaker strains, or to changes in the immunological processes of the tissues.

The fact that the antibiotics, as a whole, are not stable in aqueous mediae also is a disadvantage. Water in the preparation, in the atmosphere, in the tissues and their exudates, etc., may hamper their effectiveness to a certain degree. Again, while not common, local irritation and actual sensitization to these antibiotics have been seen. Cosmetically the antibiotics offer some problems in patient acceptance. Some have odd odors, colors, or staining qualities that are not desirable.

Finally, but of definite importance, is the fact that the antibiotics are expensive, and this adds to the already not-inconsequential cost of the steroids themselves. The economic factors may well place limits on the practical employment of these medicaments. The misleading state-

ments of certain manufacturers that they make no additional charge for the added antibiotics, is simply another way of saying that they do not pass along the savings made by omitting them.

It is evident that the topical corticosteroids would be more efficient if they could be combined with some agent having the following qualities: (A) The agent itself was proven to have antipruritic action. (B) It had bactericidal activity over a range of organisms most commonly seen in these dermatological states. Such action should not be lost after prolonged use, and possibly the agent would be of value against fungi and viruses. (C) The medicament was stable in various mediae, could be used in various types of vehicles, was readily available, and cosmetically acceptable to the patient. (D) The agent should not be likely to create local irritation or to be a high sensitizer. (E) It should not be expensive.

Quite recently certain commercially available preparations attempting to meet these standards have appeared on the market. Combinations of the steroids with tars, iodochlorhydroxyquin (Vioform®), sulfur, etc., are now being marketed. These products seem helpful, but are not ideal as yet. Experience with Crotonyl-N-Ethyl-O-Toluidine (Eurax®) indicated that it might, to a fair degree, meet the requirements, hence this study was undertaken.

EURAX AS A VEHICLE FOR TOPICAL STEROIDS

Crotonyl-N-Ethyl-O-Toluidine was first described in the European writings by Domenjoz,[4] and later in the American writings by Tronstein.[5] It was originally synthesized for use as a scabieticidal agent, and for use against certain other body infestations. Both writers noted that the material had excellent bactericidal action, and was capable of producing prompt and prolonged relief from itching. It is marketed in a 10 per cent concentration in a vanishing cream base under the trade name of Eurax. Later works by Couperas,[6] Peck and Michelfelder,[7] Johnson and Bringe[8] and others who have investigated this material have confirmed these findings.

Secondary reactions such as tingling or burning on application, are usually mild, and relatively rare. Actual sensitization has been reported in an inconsequential number of cases. This writer, having had somewhat extensive experience with this material, and having consulted others with similar experience, feels that much of the local irritation seen from its use, comes from the fact that it is being used in a 10 per cent concentration. This concentration was established for use as a scabieticide. For this purpose, the material is applied only a very few times over large areas of the body within a short period of time. Thus, as in other dermatological therapies, reducing the concentration might well eliminate the major portion of the irritations, without appreciable reduction of its therapeutic value.

Eurax offers other advantages. It is stable for long periods of time. It is insoluble in water, but readily soluble in ether, acetone, alcohol, fats, oils, etc., hence may be used in a number of vehicles. It is colorless, odorless, and does not stain. It is readily available, and is a good deal less expensive than are most of the antibiotics. Thus this item seems to come close to fulfilling the standards listed in the foregoing as being of superior merit for combination with the steroids for topical therapy.

MATERIALS AND METHODS

Approximately 200 cases from the private practice of the author were selected for this study. Of these, only 139 are included in this report; the others having been eliminated for various reasons. Some failed to return for proper evaluation, some complicated the picture with self-medication or improper use of the materials, etc. Of those not included in the study, none notified us of any serious side-reactions. The materials used were packaged in plain 7.00 Gm. tubes. Of the 139 cases reported, 30 were treated with a combination of Eurax 5 per cent with hydrocortisone 0.5 per cent; 24 with Eurax 10 per cent with hydrocortisone 0.5 per cent; and the remaining 85 with Eurax 5 per cent and hydrocortisone 1.0 per cent.

Another 30 patients, while not included in this study, were treated with Eurax 5 per cent in similar packages, and under somewhat similar conditions. This latter 30 patient group was not intended to be used for exact control studies, but was treated in the same fashion as were the other groups. This was done mainly to confirm the writer's impression that Eurax 5 per cent was clinically active, and possibly less irritating than the Eurax 10 per cent. This will be commented upon later. At times, patients were changed from the combinations to the plain Eurax, or vice-versa, without their knowledge in order to better evaluate clinical activities of these preparations.

Clinical evaluation, particularly when carried within the confines of a limited private practice, is always difficult. In this study, the author would have preferred to be able to maintain strict controls, to carry out careful pathology studies, laboratory procedures, to limit all therapy to only those materials under observation, etc., but since this was not possible, a very critical attitude was adopted. Every effort was made to properly weigh the extraneous influences of the Eurax itself, other therapy used concomitantly, psychic factors, and the benefits that Time normally bestows upon the physician's efforts.

The cases selected were for the most part, limited to those types in which one could rationally assume these materials would be beneficial. In some instances, they were selected because they were dermatological states in which nothing

TABLE 1—SHOWING NUMBER OF CASES, DIAGNOSIS, AND RESULTS ACCORDING TO EVALUATION METHOD USED

Diagnosis	No. of patients	Excellent	Good	No essential changes	Flares or Reactions
Atopic Eczema—flexural or nummular forms	10	5	3	1	1
Lichen Planus	5	1	3	1	
Localized Neurodermatitis (Lichen Chronicus)	6	3	2	1	
Irritant Types Contact Dermatitis—"housewives' hands," occupational diseases, dermatitis venenatum, etc.	32	20	10	2	
Post Cancer Radiation Therapy Dermatitis	4	3	1		
Folliculitis	8	4	4		
Stasis Eczema—with or without ulcers	8	3	3	2	
Acute Infectious Eczematoid Dermatitis	12	9	2		1
Macerated or Infected Tinea Pedis	5	3	2		
Eczematoid Seborrheic or Psoriatic States	6		4	2	
Pruritis Ani or Vulvae	8	3	3	1	1
Pompholyx or Dyshidrotic States	4	2	2		
Herpes Zoster	2	1			1
Fox-Fordyce Disease	2		2		
Recurrent Herpes Simplex	4	1	1	2	
Pustular Acne	4	1	2	1	
Solar Dermatitis	2	2			
Nail-polish Sensitivity—eyelids	2	2			
Discoid Lupus Erythematosis	2			1	1
Perionychia	3	2	1		
Misc. Conditions in which pruritis, erythema, urticarial states, lichenoid papules, etc., predominated	10	2	4	2	2
Totals	139	67	49	17	6
Totals by %	100	48	35	12	5

so far has been shown to be too helpful. A fairly good cross section of more common dermatoses was thus obtained.

All patients were instructed to apply the cream thinly two to four times daily to the involved sites. No case was considered ready for final evaluation in less than two weeks from the onset of treatment, or less than one week after treatment was stopped. Some cases were observed for more prolonged periods of time in order to see if any delayed reactions, recurrences, or similar considerations would eventuate. In a few cases comparative studies by the so-called "rightist-leftist" method were carried out, but this was only on a very limited scale.

In classifying results as to being "excellent," "good," "no essential changes," and "worse under treatment or reactions," it was felt that to be considered as "excellent," the results would have to be better than those obtained from the use of Eurax 10 per cent itself. It was also felt that these results had to be at least the equal to, or superior to, those obtained from the usual preparations of hydrocortisone alone or in combination with antibiotics. Furthermore, to be considered as "excellent," results had to be both subjectively and objectively of high order, and for as long a time as one had a reasonable right to expect it of them. If any doubt existed in any case, the classification was down-graded one step.

As was previously mentioned, in certain cases materials were interchanged with the knowledge of the patients. Recurrences, comments by the patients, etc., were carefully noted, and were used in making the evaluation of the case. In some instances, after the evaluation was completed, the patients had materials left on hand, and they were allowed to use them for other conditions. While not included in this study, we could note their effects upon other states, such as: infected bites, nickle sensitization, a violently positive patch test, etc.

RESULTS

Some twenty-odd types of dermatological conditions were treated. Table 1 shows the diagnosis, number of cases, clinically evaluated results, and totals by number and percentages. Table 2 was designed to show the differences in results according to the various types of materials used. Only those cases showing either "excellent" or "good" results were tabulated in table 2.

TABLE 2.—SHOWING NUMBER OF PATIENTS USING VARIOUS FORMS OF MEDICATIONS AND RESULTS

Material Used	No. of Patients	"Excellent" or "Good"	By %
Eurax 5% plus hydrocortisone 0.5%	30	21	70
Eurax 5% plus hydrocortisone 1.0%	85	78	91
Eurax 10% plus hydrocortisone 0.5%	24	17	71
All forms in combination	139	116	83
Eurax 5% without added hydrocortisone	30	20	67

While special figures are not herewith supplied, it may be stated that in no case in which infection was not present at the onset of treatment, did infection later take place. In those cases in which infection was seen at the start, in almost every instance it was definitely reduced within a short time. If the infection did not clear completely by this means, other types of treatment were then used.

In some instances, especially if marked local irritation was present at the start, the patients sometimes complained of burning or tingling upon applying the materials. Usually these complaints were not too severe, and the medication was continued. Usually as the case improved,

the complaints were reduced, and for the most part, could be ignored entirely.

It is interesting to note that there is a significant rise in efficiency when the hydrocortisone concentration is raised from 0.5 per cent to 1.0 per cent. One might speculate as to whether raising it higher would show additional benefits. From the results obtained from this small series, one sees little, if any great differences in results between Eurax 5 per cent, Eurax 5 per cent with hydrocortisone 0.5 per cent, and Eurax 10 per cent with hydrocortisone 0.5 per cent. Possibly a larger series would show such differences.

It also seems somewhat evident that the types of cases deriving the least benefit from these items, are those in which dermatologists usually do not get really good results with any other agent. Thus, an atopic individual may be doing quite well, but flare after a mental upheaval. Other such examples are also seen here.

SUMMARY AND CONCLUSIONS

1. The topical corticosteroids, while enjoying widespread use, find their peak efficiency in those dermatological states in which suppression of inflammation, is most likely to alleviate the condition.

2. The suppression of inflammation does not necessarily produce cure, or relieve such symptoms as itching or tingling. Such suppression of inflammation does, however, render the tissues more susceptible to infection.

3. In order to render infection while under such topical steroid therapy less likely to occur, it has become common practice to incorporate antibiotics into the steroid preparations, or to supplement these with systemic antibiotic or chemotherapy.

4. The antibiotics, while useful, offer some disadvantages which might be overcome by replacing them with Crotonyl-N-Ethyl-O-Toluidine (Eurax) in combination with the topical corticosteroids.

5. One hundred and thirty-nine patients were treated with combinations of hydrocortisone and Eurax. The patients were from private practice, and represented some 20 types of dermatological states. Of this 139 patients, 67 (48 per cent) showed "excellent" results; 49 responded in "good" fashion; 17 (12 per cent) exhibited "no essential changes," and the remaining six (5 per cent) showed either "flares or reactions under therapy," according to the standards established for the evaluation. Combinations of Eurax 5 per cent with hydrocortisone 1.0 per cent, Eurax 10 per cent with hydrocortisone 0.5 per cent, and Eurax 5 per cent with hydrocortisone 0.5 per cent were used. Another group of 30 patients not included in this study, were treated with Eurax 5 per cent, and results evaluated similarly.

6. Comparison of the various combinations of Eurax and hydrocortisone showed that using 1.0 per cent hydrocortisone is more effective than when only 0.5 per cent is used. Eurax 5 per cent alone seems about as effective as those combinations containing 0.5 per cent hydrocortisone with either concentration of Eurax. These results are more closely seen by examination of table 2.

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Minimum Requirements for Tuberculosis Control in Institutions

After a review of all pertinent factors, the Committee on Chest Diseases in Institutions, American College of Chest Physicians, has formulated the following minimum requirements for tuberculosis control programs in penal and mental institutions:

1. The program shall be under the direction of an experienced chest specialist who shall supervise the case finding as well as the clinical work.

2. The program shall incorporate complete case finding procedures including x-raying of all new admissions, pre-employment examinations and periodic institutional surveys, at least annually.

3. Every new admission shall have a tuberculin skin test and negative reactors shall be retested at least annually.

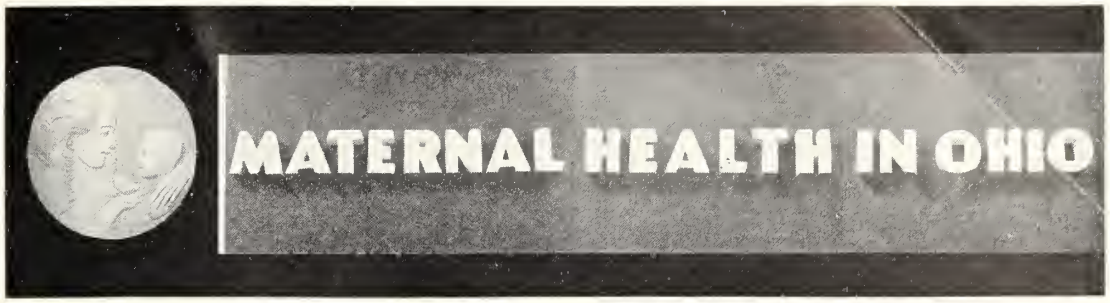
4. Proper clinical and laboratory facilities for diagnosis of chest conditions shall be available.

5. There shall be adequate provisions or arrangements for medical and surgical treatment of tuberculosis.

6. Periodic, frequent follow-up of all inactive cases of tuberculosis in the institution.—Excerpt from "Report of the Committee on Chest Diseases in Institutions," The American College of Chest Physicians.

Heparin and Dicumerol

The use of these two preparations has been of great value in the treatment of thrombophlebitis and in coronary thrombosis. In thrombophlebitis, the embolic phenomena has been reduced by 65 per cent, whereas the death rate of patients with coronary thrombosis has been markedly reduced. The exact percentage is not known.—L. Maxwell Lockie, M. D., Buffalo: *Arizona Med.*, 14:143, March 1957.



TOPIC THIS MONTH:

Maternal Deaths* Involving Infection

CASE No. 62

This patient was a 36 year old Para IV, who expired 11 days postpartum in an anuric state. Her previous pregnancies were uneventful and her prenatal course during the current pregnancy was normal. She was admitted to the hospital July 17 in labor, at term, with history of membranes having ruptured four days prior to onset of labor. On physical examination her temperature was 103°, fetal heart tones were not heard, and the umbilical cord could be palpated through an undilated cervix.

Since she was known to be allergic to penicillin, she was placed on tetracycline therapy. She had chills and at one time during labor her temperature rose to 107°. Labor progressed slowly and after 18 hours she delivered spontaneously a dead fetus on July 17th. She was given ½ unit of blood. The following morning she was found to be anuric; she received another ½ unit of blood. Obstetrical and urological consultations were obtained. She continued to have only scanty amounts of urine for the next nine days under medical treatment, and on the tenth day she was transferred to a metropolitan hospital for "artificial kidney" therapy; however she expired before this equipment could be employed on her. Laryngospasm developed. A tracheotomy was done immediately preceding her death. Permission for autopsy was granted.

Pathological Diagnosis: Bilateral cortical necrosis; postpartum uterus, 11 days; emphysema, focal, lungs; acute splenitis; acute congestion, liver; erosive esophagitis; ascites; cystitis, mild; endometritis due to Streptococcus hemolyticus and Aerobacter aerogenes; tracheotomy, recent; herpes simplex labialis.

COMMENT

The Committee very justifiably considered this to be a nonpreventable maternal death. The presence of the puerperal sepsis during the intrapartum period set the stage for the events which followed. The exact nature of the treatment of her anuria postpartum was not stated; however, knowing the resistant nature of this unfortunate complication, the Committee proceeded to vote as above without further attempt to evaluate the adequacy of the treatment.

CASE No. 106

This patient was a 40 year old obese female, gravida VI, Para V, who died undelivered at 32 weeks gestation. She was admitted to the hospital in critical condition on November 20 without previous prenatal care. She was reportedly well until 24 hours prior to admission at which time she developed some productive cough associated with vomiting. Data on her past history and previous pregnancies were not reported.

Initial examination in the emergency room revealed an acutely ill, comatose, dyspneic female who appeared to be about eight months pregnant. Her pulse was 150 to 160 per minute, blood pressure 130/98, temperature 100.6° (rectal), and respirations 48. Fetal heart tones were not definitely heard. An electrocardiogram showed the presence of auricular fibrillation. Portable chest films were unsatisfactory, but the diagnosis of acute pulmonary edema with fibrillation was made. The admission white blood count showed 51,000 white blood cells with extreme shift to the left; the urine contained 4 plus albumin with many red blood cells and white blood cells; hemoglobin was reported as 12.5 Gm. with hematocrit of 43.

In the presence of cyanosis and rattling respirations, heroic treatment measures were undertaken including phlebotomies, morphine, aminophylline, diuretics and digitalis. In addition oxygen, antibiotics, and throat suction were used; however the patient failed to respond to this regime. Her condition rapidly deteriorated and she expired, undelivered, 23 hours after admission. No effort was made to do a postmortem cesarean section. Permission for autopsy was obtained.

Pathological Diagnosis: (Included) confluent bronchopneumonia with tremendous pulmonary edema right and left lungs; overwhelming sepsis with toxemia (clinical); pregnancy, uterine, near term; general hypertrophy of all body organs (heart, spleen, liver, pancreas and kidneys); toxic splenitis; hydropericardium; arteriosclerosis, aorta and coronary arteries.

COMMENT

The Committee voted this a nonpreventable maternal death. There was considerable discussion as to whether or not this should be termed a maternal death since there was no conclusive

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

evidence to show that her pregnancy was a chief factor in her death; however it was finally decided to classify this as a maternal death for statistical purposes on the basis that the pregnancy indirectly had been a contributing cause.

CASE No. 128

This patient was a 32 year old white obese female, Para II, who died on the first day postpartum. The past history was not remarkable. Her first pregnancy and delivery two years previously were uneventful. Her initial examination at three months was normal except for the presence of a mitral murmur; her prenatal course was normal in all respects.

She was admitted to the hospital on February 9 in active labor at which time she had a "cold" with slight temperature elevation, but the chest was clear to auscultation and there were no abnormal cardiac findings. After a nine hour labor a Scanzoni rotation on a right occipitoposterior presentation was attempted with the patient under anesthesia (agent not mentioned). This was unsuccessful so an internal podalic version was done with difficulty. A 9 pound 9 ounce baby was delivered which was cyanotic and expired a few hours later. The mother vomited once during delivery and became cyanotic, but this did not persist.

The following morning the patient had a temperature of 101.4° and was dyspneic and cyanotic and had a pulse rate of 140 per minute even though she was in an oxygen tent. The blood count revealed 4.08 million red blood cells with 12.3 Grams hemoglobin; 34,550 white blood cells with 91 per cent polymorphonuclear leukocytes, the majority of which were stab and segmented forms. The chest x-ray showed an extreme degree of bilateral congestion and edema with moderate cardiac enlargement. Despite adequate treatment including antibiotics, fluids and digitalization the patient expired 29 hours after delivery. Autopsy permission was obtained.

Pathological Diagnosis: Extensive confluent bronchopneumonia; old tuberculosis of peribronchial lymph nodes; persistent thymus; recent postpartum state; acute passive congestion and parenchymatous degeneration of all organs.

COMMENT

The Committee voted this a preventable maternal death. It was felt that perhaps this patient should have been allowed to labor longer rather than being subjected to a difficult internal podalic version after only nine hours of labor. The trauma of delivery plus the (probable) aspiration of vomitus were apparently the main predisposing factors to subsequent development of her fulminating pneumonitis. There is no mention in the record of consultation having been obtained prior to the undertaking of the version. Also, information regarding cervical dilatation and station of the head was not included, but on the basis of the information at hand it was felt that personnel misjudgment was a major factor in the fatal developments which followed. The type of anesthetic as well as details of its administration were not recorded.

COMMENT OF CONSULTANT

The following comment of a consultant who is a specialist in Obstetrics and Gynecology, was given at the request of the Committee.

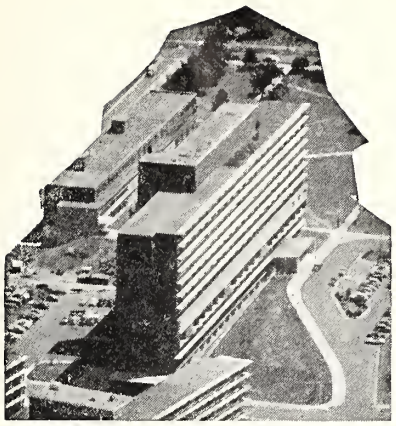
Infection of the birth canal, once the dreaded danger of birth and the leading cause of maternal death, has been displaced as killer number one by both hemorrhage and toxemia. Case reports Nos. 62, 106 and 128 demonstrate only too sadly the fact that puerperal infection is STILL one of the three greatest causes of obstetric mortality and morbidity and remains the commonest complication of the puerperium. During pregnancy and the first few hours of labor, the uterus and amniotic sac are sterile, but after labor has been in progress for several hours and especially after the membranes have ruptured, bacteria previously confined to the vagina and cervix begin to gain access to the uterine cavity. While the routine prophylactic use of antibiotics are not recommended as an obstetric routine, there are certain situations which are so frequently associated with puerperal infection that they make desirable the prophylactic administration of antibiotics. Included are prolonged rupture of the membranes, prolonged labor, traumatic delivery, postpartum hemorrhage, anemia from other causes such as sickle cell anemia and intra-uterine manipulations such as manual removal of the placenta or tamponade by packing.

The diagnosis of puerperal infection is usually made by fever alone, even in the absence of specific symptoms or physical findings, when mastitis, urinary infection, and respiratory infection can be excluded. Before specific therapy is begun it is desirable to obtain an intra-uterine or intracervical culture, which should be incubated aerobically and anaerobically. The results of the culture may later necessitate modification of the therapy according to the particular organisms involved and their sensitivity to specific antibacterials, but treatment should not be delayed while awaiting culture reports.

Acknowledgment: With this issue, the "Maternal Health in Ohio" column enters its second year of publication. The Committee on Maternal Health takes this opportunity to acknowledge with gratitude the wholehearted cooperation of Ohio physicians, county chairmen, and many others, without whose untiring efforts and assistance this study could not be maintained.

Identification of Mumps Virus From Cerebrospinal Fluid

The usual course of mumps meningoencephalitis is self limited and so benign as seldom to indicate hospitalization. Since the findings in the spinal fluid may be of much importance in establishing the diagnosis, it is probable that many patients will require hospitalization for the performance of a lumbar puncture and a short period of observation.—Henry B. Bruyn, M. D., et al., San Francisco: *California Med.*, 86:153, March 1957.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Ralph J. Johansmann, M. D., President

Presented by George Nelson, M. D., and Emmerich von Haam, M. D. Edited by Dr. von Haam

PRESENTATION OF CASE

THIS 58 year old female Negro was admitted to the University Hospital with a chief complaint of intermittent suprapubic pain of three months' duration. The pain did not radiate to the back, was aggravated during urination, and was somewhat relieved following urination. She also had a progressive weakness and loss in body weight of about 80 pounds. She had had rather severe dysphagia for the past three months both for solid and liquid foods. There also was occasional nausea and vomiting. The patient had progressive signs of urgency and frequency of urination with dysuria for the past three months, but there was no history of nocturia or hematuria.

PHYSICAL EXAMINATION

The patient was an emaciated, lethargic Negro who appeared much older than her stated age of 58 years. The blood pressure was 160/80, the temperature 101°F., the pulse rate 120 per minute and respirations 28 per minute. The right tonsil was enlarged. There was no cervical or supraclavicular lymphadenopathy. There was a pretracheal mass which was quite firm and rounded. It was stated that this mass had been present without change for the past 20 years. The chest was clear to percussion and auscultation. Auscultation of the heart revealed no murmurs. The breasts were atrophic. The liver edge was palpable two fingerbreadths below the right costal margin. The bladder was distended to the level of the umbilicus but there was no abdominal tenderness. The extremities showed evidence of peripheral edema. The neurological examination was within normal limits.

LABORATORY DATA

White blood cell count was 9,600 with 70 per cent polymorphonuclear neutrophil leukocytes, 29 per cent lymphocytes; red blood cell count was 2.6 million, with a hemoglobin of 8.3 Gm. per 100 ml. Examination of the urine revealed the presence of 5 mg. per 100 ml. protein; the sediment was loaded with white blood cells and bacteriological examination revealed the presence of Escherichia coli, Klebsiella and unidentified yeasts. The blood sugar was 157 mg. per 100 ml., prothrombin time 57.5 per cent of normal, serum potassium 3.5 mEq. and chlorides 96 mEq. The blood serology was negative for syphilis. The serum proteins were 9.3 per cent with 3 per cent albumin and 6.3 globulin. The van den Bergh test was 1.1 units indirect and 0.7 units direct and the blood urea nitrogen was 54 mg. per 100 ml.

The serum cholesterol was 100 mg. per 100 ml., the radioactive iodine uptake 41 per cent. Spinal fluid examination revealed the presence of 57 red blood cells per cu. mm. and 2 white blood cells per cu. mm; there was no globulin in the spinal fluid. The spinal fluid sugar was 149 mg. per 100 ml., chlorides were slightly elevated to 767 mg. per 100 ml. and the proteins were within normal range.

ROENTGENOGRAPHIC EXAMINATION

Chest x-rays showed that her lung fields were clear. The heart was enlarged and measured 132 mm. in transverse diameter. Her substernal region contained a soft tissue mass with areas of calcification, probably representing a diffusely enlarged or nodular thyroid. The rib cage showed marked demineralization and some of these areas may be compatible with myeloma or osteoporosis The abdomen did not show anything remarkable. The lumbar vertebrae and the pelvis showed osteoporosis.

HOSPITAL COURSE

Shortly following her admission, an otolaryngeal consultation was obtained and it was felt by the consultant that the enlargement of the right tonsil was not due to a neoplasm. Urologi-

cal consultation suggested a neurologic origin of her urinary retention. On her third hospital day, the patient developed a left-sided weakness and shortly following this, a tachycardia of 180 heartbeats per minute. She was treated with hydrocortisone, thiouracil and intravenous fluids. The temperature remained between 101° and 102°F. rectally. The patient continued to be quite restless but on her third hospital day became suddenly quite stuporous. The eyes rolled to the right and she did not respond to painful stimuli. The left arm became quite flaccid and there was a weakness of the left leg. For the next day, the patient remained quite stuporous, went into a deep coma, and expired quietly on her fourth hospital day.

CLINICAL DISCUSSION

DR. GEORGE NELSON: This is a 58 year old female Negro who was admitted to University Hospital with a chief complaint of intermittent suprapubic pain of three months' duration. She did have a slight systolic hypertension and fever which continued during her hospital stay. All her urines showed a low specific gravity and a lot of white blood cells with only a little albumin, and her blood sugar was definitely elevated. She also excreted sugar in her urine part of the time. In other words, there is no question but that she was at least a mild diabetic. Her electrocardiogram did not show anything but a sinus tachycardia. She had lost a lot of weight.

Of course, one of the difficulties that a diabetic gets into is infection, and one of the places where he would tend to have infection is in his urinary tract. Besides that, diabetics also tend to develop neurologic lesions, such as a cord bladder. Such a bladder often becomes infected and from this, the patient could develop pyelonephritis which could have been responsible for her diminished renal function, as evidenced by the low specific gravity of the urine and her elevated blood urea nitrogen.

A diabetic patient also frequently suffers from arteriosclerosis. Arteriosclerosis, as you know, involves often the central nervous system and diabetics are extremely prone to develop multiple thromboses, involving the vessels of the brain. Therefore, it would be reasonable to suppose that the patient was a diabetic who had developed a cord bladder, a chronic pyelonephritis with some diminution in renal function, and an arteriosclerosis of the vessels of the central nervous system with cerebral artery thrombosis. It seems to me that she might have died as a result of the latter lesion. I consider it quite possible that a diabetic patient, even though his diabetes may have been mild but present over a long period of time, would have followed the course demonstrated in our patient.

Her serum proteins were 9.3 mg., which is very definitely high. There is a very definite increase in the globulin content with a reversal of the albumin : globulin ratio. As far as I am concerned, when I see a serum protein of that type, I think of multiple myeloma. This individual is at the right age where multiple myeloma does develop, they do get difficulties neurologically with involvement of the spinal cord, and as a matter of fact, in the few that I have seen, the first symptom was pain in the back, and that is the first symptom that this individual had. So seeing that particular blood picture and the serum proteins, I would be very suspicious of a multiple myeloma.

Her roentgenograms partly seem to confirm this suspicion, but the radiologist was more inclined to diagnose the bone lesion as one of widespread osteoporosis. No skull films were taken. Her blood cholesterol was a little bit low, which I think could probably be accounted for by her poor nutrition at state. I don't believe that it was of any particular significance except for starvation. She did have a nodule in her thyroid. The thyroid function was examined by the method of radioactive iodine uptake and appeared to be normal.

So it still is my opinion on this particular patient that she did have diabetes, generalized arteriosclerosis, and chronic pyelonephritis. I cannot rule out definitely a multiple myeloma, which also may explain some of her neurological symptoms. However, they could be better explained on the basis of arteriosclerosis, probably with thrombosis.

GENERAL CLINICAL DISCUSSION

DR. VON HAAM: I selected this case because this patient came to us with a clinical diagnosis of carcinoma and the following sites were considered: Gastrointestinal tract including esophagus and stomach, the pancreas, the urinary bladder, and the right tonsil. In addition, the clinician felt that she had Addison's disease, toxic goiter and diabetes. Now Dr. Nelson has apparently eliminated the diagnosis of cancer from this discussion entirely. Multiple myeloma was also considered by the clinical staff. The suspicions of multiple myeloma by Dr. Nelson, is based primarily upon the hyperglobulinemia. Did the radiologist support this diagnosis?

DR. NELSON: She had rib changes, but it is impossible to differentiate between myeloma and osteroporosis in this case.

DR. NELSON: The reason I did not mention anything about a malignancy is because there is nothing in the history or physical examination to pinpoint such a neoplasm.

DR. VON HAAM: Another symptom which has not been explained is her terrific and rapid loss of weight. Could her dysphagia have been responsible for this? Finally, why did this patient die? Did she die because of her weight loss, did she die because she had an infection, or

did she die because, as Dr. Nelson thinks, she had a cerebral vascular accident?

QUESTION: Did she have a sickle cell preparation?

DR. NELSON: Yes, and it was negative.

QUESTION: She had urgency and frequency. Would that suggest a neurogenic bladder?

DR. NELSON: I think it does not, but the Genitourinary Department was inclined to say that she had a cord bladder.

QUESTION: Why was the spinal fluid sugar so high?

DR. NELSON: Because the blood sugar was high.

CLINICAL DIAGNOSIS

1. Diabetes mellitus.
2. Chronic pyelonephritis.
3. Generalized arteriosclerosis.
4. Recent cerebrovascular accident.
5. Nodular colloid goiter.
6. Possible multiple myeloma.
7. Starvation cachexia.

PATHOLOGICAL DIAGNOSIS

1. Diabetes (clinical).
2. Acute and chronic pyelonephritis.
3. Generalized arteriosclerosis.
4. Old and recent encephalomalacia.
5. Nodular colloid goiter.
6. Hypochronic anemia with dysphagia.
7. Starvation cachexia.
8. Terminal septicemia.

PATHOLOGICAL DISCUSSION

DR. VON HAAM: The autopsy showed a body which was well developed but extremely cachectic, weighing about 80 pounds. The skin was dehydrated, dry, and wrinkled. The tumor in the thyroid region was large enough to be easily seen and palpated and could well have been a cause of her dysphagia. The heart weighed 265 grams which, for a person of her size, means that it was enlarged. The ventricles were dilated and the heart muscle was soft. All anatomical structures of the heart were perfectly normal, including the coronary arteries. Both lungs were normal, the spleen was enlarged and soft. The liver was decreased in size, brown and soft. The gallbladder was normal. The pancreas was small and weighed only 50 grams. It was soft, gray, and lobulated.

Because of her alleged dysphagia, the pharynx was carefully examined together with the esophagus and larynx. The right tonsil was larger than the left and measured 24 mm. in largest diameter. Otherwise, no abnormalities were found which could account for her dysphagia. The previously mentioned thyroid nodule contained many cysts filled with colloid and areas of calcification. The mucosa of the stomach was thin and atrophic.

The kidneys were large and irregular and the cortex was studded with numerous small abscesses filled with yellow pus. The abscesses measured up to 3 mm. in diameter, were single or in small groups, and continued in the form of ill-defined yellow streaks into the medulla. There were few small cortical cysts filled with cloudy fluid. The renal pelves were not dilated. The ureters were straight and slender. The wall of the urinary bladder was slightly thickened and trabeculated. The mucosa was edematous and hemorrhagic. The lumen contained some purulent urine. The urethra was normal. The sex organs were involuted. All vessels were extremely sclerotic.

The brain weighed only 970 grams and showed many small areas of circumscribed encephalomalacia. A comparatively large and cystic area of recent softening was found in the right basal ganglia. All brain vessels were extremely sclerotic. Examination of the skeletal system revealed moderate osteoporosis of all bone. The bone marrow was uniformly pale red and soft.

MICROSCOPIC EXAMINATION

Section through the heart muscle showed rather severe fatty degeneration of the myocardium. Section through the lungs showed only moderate emphysema. The spleen was congested and contained many leukocytes in the pulp. Sections through the pancreas revealed no histologic evidence of insulin deficiency, a finding present in the majority of clinical cases of diabetes. The mucosa of the entire gastrointestinal tract was atrophic with special emphasis upon the mucosa of the stomach. A survey of the endocrine glands revealed no striking pathological changes. The thyroid nodule was a nontoxic adenoma with severe involutional changes. The microscopic examination of the kidneys showed a very acute and severe purulent pyelonephritis. The bladder wall was moderately hypertrophic and the mucosa showed acute inflammatory changes. Sections through the brain confirmed the presence of multiple old and recent areas of encephalomalacia on an arteriosclerotic basis. Examination of the bone marrow showed a depressed bone marrow without evidence of megaloblastic reaction such as found in pernicious anemia.

In summary, we have here a patient who suffered from mild clinical diabetes of unknown duration, severe generalized arteriosclerosis and an anemia of the hypochromic microcytic type as found in conditions of iron deficiency. The severe mucosal atrophy of her gastrointestinal tract may have been responsible for her dysphagia (Plummer-Vinson syndrome) together with pressure from her calcified thyroid adenoma. The anemia and subsequent starvation cachexia led to myocardial degeneration which caused an enlarged dilated heart.

Her severe arteriosclerosis was responsible for her cerebral lesions which must have been occur-

ring for some time. She finally developed a severe acute pyelonephritis and died a septic death. The remarkable feature in this case was that the patient, although the course of her disease was rather typical for a malignant neoplasm, did not suffer from cancer.

GENERAL DISCUSSION

DR. NELSON: I have a hunch that the history of the patient was not correct, and that she did not lose all that weight in the last three months. She must have been ill longer than three months. Why did she have the high serum proteins?

DR. VON HAAM: Could the inflammatory process in the kidneys explain such a high protein? Of course, we did not examine all the bones, but she did not have multiple myeloma.

QUESTION: What was the primary focus for her infection?

DR. VON HAAM: It may have been the tonsil, but as in instances of osteomyelitis, the kidney became the primary focus for her septicemia.

QUESTION: When a diabetic loses weight, the prognosis is pretty poor, isn't it, and the diabetes becomes hard to treat?

DR. NELSON: She had not been on insulin before she came in. She was given a little insulin while she was in here. Her CO_2 combining power was all right, but many of those old diabetics die like she did—from a fatal infection.

Contraindications to Anticoagulants In Myocardial Infarction

Probably the most definite contraindication to the use of anticoagulants is in the group of patients who have known ulcerative lesions in the gastrointestinal tract. Gastrointestinal bleeding is difficult to control as well as being insidious and hard to evaluate. Patients with severe liver disease and patients having a blood dyscrasia and known hemorrhagic tendencies should be treated either not at all, or with great caution. A history of epistaxis or bleeding from hemorrhoids is not considered to be a contraindication since these problems can usually be controlled satisfactorily in hospitalized patients.—John S. Powers, Jr., M. D., Kingsport, Tenn.: *J. Tennessee M. A.*, 50:278, July, 1957.

Survey of Human Allergy To Pit Viper Venom

A survey of allergy to North American pit viper venom in 30 patients with one or more previous envenomations showed seven of them were allergic to venom. Scratch tests using fresh undiluted cottonmouth moccasin *(A. piscivorus)* and rattlesnake *(C. adamanteus)* venoms were used to detect hypersensitivity to venom. The presence of hypersensitivity was confirmed by Praustniz-Kustner tests. — Henry M. Parrish, M. D., M. P. H., New Haven, Conn.: *Arizona Med.*, 14:461, August, 1957.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.

Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met on August 21, 1957, at the Columbus Health Center. Three cases were presented.

Case No. 1: A 58 year old white female who experienced an onset of vaginal bleeding and profuse discharge shortly after discovering she was a diabetic. She had been treated for diabetes and hypertension for approximately two years by her family physician, but she did not take the vaginal bleeding seriously and no diagnosis was made until 27 months after first symptoms. She had a cervical biopsy and dilatation and curettage. She was then referred into clinic. *Diagnosis:* Poorly differentiated epidermoid carcinoma of the cervix, clinical stage 3. *Treatment:* She received 7,000 r. cobalt-60 by colpostat and tandem followed by 9,000 r. to four pelvic fields externally.

When patient was last seen, there were radiation changes of the vagina. No lesions visible. There was bilateral thickening near pelvic wall which was pliable and was not indicative of tumor.

Comments: DR. J. H. HOLZAEPFEL: Physician delay 15 months.

Case No. 2: A 34 year old white female whose first symptoms were in April. She had had profuse vaginal bleeding since birth of last child, late April. Saw her physician and was treated for dysuria and frequency and vaginal bleeding. Also treated for kidney infection, but no pelvic examination was done. She reported to another physician one year later and was referred to clinic. Seen in the emergency room and the report from a biopsy of tissue was poorly differentiated squamous cell carcinoma of the cervix. *Diagnosis:* Confirmed on admission carcinoma of the cervix, clinical stage 2. *Treatment:* Patient received 7,000 r. cobalt-60 by colpostat and tandem, and 3,500 r. external therapy.

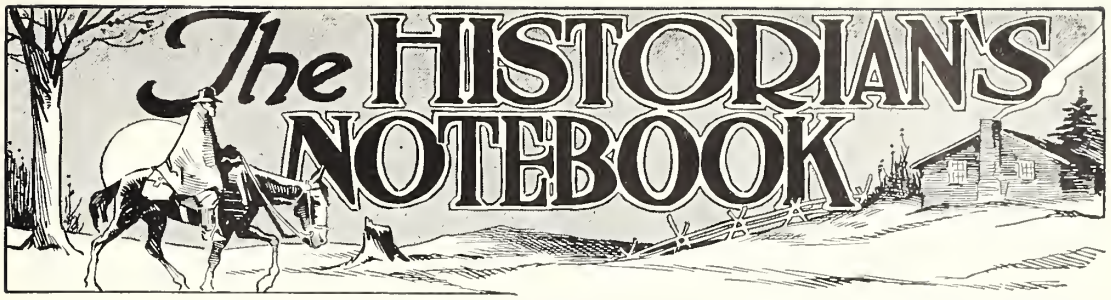
Comments: DR. HOLZAEPFEL: Physician delay one year.

DR. H. E. EZELL: All postpartum bleeding which is abnormal should be investigated.

Case No. 3: A 43 year old white female first had symptoms when she had abnormal menstrual bleeding between periods. Saw her physician who believed she was entering the menopause. Treated with shots for one month. Three months later she received 7,560 milligram hours of radium after diagnosis was made two months before of carcinoma of the cervix, stage 3. She was then referred into clinic. *Treatment:* Patient further received 3,000 r. externally. Four months following this treatment patient was admitted and a high dorsal chorodotomy, right and left, was performed. When last seen the patient was terminal.

Comments: DR. EZELL: Physician delay of one month.

DR. HOLZAEPFEL: Brevity of time loss not the major factor with this patient. There can be far advanced disease with no symptoms. Periodic checkup is only solution for this problem.



Hospital Transports

With Special Reference to the Steamboat *Allen Collier* and the Cincinnati Branch of the U. S. Sanitary Commission

ROBERT H. PRESTON, M. D.

PART II

(Concluded from September Issue)

THE ALLEN COLLIER

UNDER these circumstances the arrival of a ship load of supplies and doctors should have been received with open arms but instead *The Allen Collier* was looked upon as an interloper. The general opinion of the Union medical staff was that the outsiders were trying to meddle and intrude. The aid was greeted with curses and at first refused but finally partially accepted under conditions, "So humiliating and insulting that nothing but a high sense of duty and total disregard of self, prevented the Christian gentlemen from leaving the wounded and returning as they came." By persevering effort *The Allen Collier* was able to take 81 of the wounded to a military hospital in Cincinnati, this being the first recorded trip of a United States Sanitary Commission hospital steamer in the western battles.

During the battle at Pittsburgh Landing and Shiloh, April 1862, more boats responded to the need. The Union Government sent a hospital ship, *The City of Memphis*, and steamers, *Hiawatha*, *J. J. Roe*, *War Eagle* and *Crescent City*. Later government hospital boats, *Louisana*, *D. A. January*, *Empress* and *Imperial* made their appearance.

Volunteer boats continued to offer their service. A boat from Louisville received special praise. Its captain cooperated in a most satisfactory manner with the medical director. No discrimination was shown to the men of Kentucky. The wounded of other states as well as Confederate prisoners were received and aided. It is to be regretted that the same liberal spirit did not animate all of the volunteers that hurried to the scene. In some cases boats fitted out by governors of states endeavored to distinguish between the wounded of their own and other states, thus refusing to accept those not eligible for their aid.

So great did this illiberal conduct conflict with the Medical Department that it became necessary to declare that all state distinctions should be ignored and the helpless soldiers, friend or foe, should be cared for alike. An example of this is found in a medical report of surgeon David P. Smith, U. S. Volunteer, "The most painful feature, however, that I encountered was the inhumanity shown by state agents. One steamboat captain, I remember, who came from Cincinnati with a steamboat fitted with every hospital convenience and who flatly refused to receive any but Ohio wounded on his boat and entirely ignored the authority of any medical officer."

This existing condition partially led to a great deal of malingering. When it was once understood by a group of soldiers that a boat from their state lay at the landing for the reception of the sick, it was impossible to prevent the flocking on board of many whose only complaint

The Author

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Presented at the meeting of the Ohio Historical Society in Cleveland, April, 1957.

was nostalgia. The real sick were left behind and the convalescent and malingerers were sent home. General McClellend's medical director, Charles S. Tripler said, "I am sure hundreds of malingerers succeeded in deserting their colors on hospital transports in spite of every effort of mine to stop it."

Inspired by the experience at Pittsburgh Landing and Fort Donelson, the government fitted up four excellent hospital boats. They were so adequate that little was left for the Sanitary Commission to do in that direction.

HOSPITAL TRANSPORTS IN THE EAST

When the war started to move from the high banks of the Potomac to the low swampy area of the peninsula, in the early part of 1862, the hospital transports appeared with the Army of the Potomac. Here again the government was not prepared for the care of the sick and wounded. After tedious delays and repeated disappointments Stanton gave approval for the Sanitary Commission to take some of the transport steamboats of the Quartermaster Department. These boats were lying idle and were to be equipped for medical care at no cost to the government.

In Olmsted's own words, "After tedious delays and disappointments, order was at length received, authorizing the Commission to take possession of any of the government transports not in actual use which were lying at Alexandria. The only vessel stanch enough proved to be the *Daniel Webster*, an Old Pacific coast steamer of small capacity recently used for troop transport and was stripped of everything movable but dirt."

On April 25, 1862, *The Daniel Webster* steamed to Fort Monroe under the direction of Olmsted. While on voyage personnel was forced to reconstruct the interior of the boat. Nurses, surgeons and carpenters worked together to knock out bulkheads in the wings of the engine room to gain a draft. They divided cabins and upper steerage into six wards. *The Daniel Webster* was then capable of caring for 250 patients. One surgeon, two interns, four nurses, convalescent soldiers and Negro helpers staffed each ward.

The quartermaster also at this time assigned two ships to surgeon Tripler. These were *The Commodore* and *The William Whilden*. They became receiving ships and not true hospital transports. Their function was to move the wounded. The men were literally packed in the vessel due to a lack of space. The accommodations and facilities were horrible. The description of the odor, pain and filth reminds one ironically of slave boats.

After a short period of time, the Commission replaced *The Daniel Webster* with a much larger ship, *The Ocean Queen*. It served very well for hospital purposes until Quartermaster General Meigs replaced it with the large, but unseaworthy, *S. R. Spaulding*, a cavalry transport. *The Spaulding* served as a reserve hospital for the gravest cases.

Later additions were *The Daniel Webster No. 2*, *Wilson Small, Elizabeth*, and *Wissahickon*. These were boats of light draft and they ran up creek to bring casualties down to the floating hospital.

The Elm City accommodated 400 surgical cases. The wide decks offered plenty of room for the cots and mattresses of the wounded. This large river boat carried its human cargo up the Potomac to Washington.

The Knickerbocker was very old, low between decks, poorly ventilated, and of small capacity. But it managed to transfer 250 wounded from White House to Fort Monroe every 24 hours.

The St. Mark, a delight to the eyes, was a clipper ship down from the East Indian trade. *The St. Mark* and *The Enterpe* carried their own surgical corps. Because of their large size they stayed at Yorktown while lighter boats brought to them the sick and wounded.

RULES AND REGULATIONS

A copy of the regulations for the "Floating Hospital Service of the United States Sanitary Commission" which was taken from Olmsted's *Hospital Transport—A Memoir*, reads as follows:

"1—An agent of Administration for the Commission will be appointed for each hospital vessel and will be responsible for her fittings and supplies.

"2—Each vessel will be divided into hospital wards designed to accommodate 50-150 patients.

"3—One surgeon will be in charge of each vessel and if practical a surgeon for each ward.

"4—Assistants to surgeons, or Wardmasters, will be under instruction of the surgeon to be responsible for the ward." (These were usually 2 year medical students.)

"5—Two or more nurses will be on duty in each ward at all times.

"6—There will be a dispensary on each vessel and one or more apothocaries will be placed in charge.

"7—The hospital pantry and linen closet will be in custody of ladies who will issue special diet, drink, article of bed and personal clothing for patients.

"HOUSE DIET:

Breakfast—to be ready at 7:00 a. m.
bread (or toast) with butter
coffee or tea.

Dinner—to be ready at 1:15 p. m.
beef soup & boiled beef or beef stew
boiled rice or hominy
bread or crackers.

Tea—to be ready at 7:00 p. m.
bread or toast or crackers with butter
coffee or tea.

"Surgeon will ascertain special diet to patients."

END OF A JOB WELL DONE

The floating hospital service cost the Commis-

sion about $200,000.00 a month. Government officers paid little heed to the Commission's advice as they were not officially responsible to them. Army doctors chose Army boats because they were of their own branch of service. However, their decision implied neither disrespect nor hostility to the Commission. The Army man used discretion and would not chance gaining disfavor of another government official, particularly one of higher rank. Therefore, even though the Commission ferried 8,000 to 10,000 casualties, its ships became of lesser service.

Olmsted worked diligently to force the Army to use the boats but to no avail. So on June 26, Surgeon General Hammond was forced to take over the Sanitary Commission's boats and Letterman, who had replaced Tripler as Medical Director of the Potomac Army, agreed to accept the doctors of the Sanitary Commission. He took all male nurses but left the women nurses to the discretion of the officers in charge of each boat. So the Sanitary Commission hospital transports came to an end and the responsibility was placed in the hands of the United States Government.

In looking over old papers and books to collect this material I was enlightened by the progress that has been made in the past 95 years. I was surprised to find how active a part the civilian played in providing a medical service during the Civil War. The Army took over the hospital transports but a great deal of credit must be given to the non-service men, in the form of the Sanitary Commission. Through them the groundwork had been laid and the improvements had been instigated.

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History of the Therapy of Tuberculosis and the Case of Frederic Chopin, by Esmond R. Long, M. D. ($2.50. *University of Kansas Press, Lawrence, Kansas.)* This is the sixth Logan Clendenning Lecture on the History and Philosophy of Medicine. The author, a distinguished authority on tuberculosis, and a medical historian of note, has traced his subject from Hippocrates to modern times. In this series of lectures he has done credit to the memory of Dr. Clendenning and justified Mrs. Clendenning's thoughtfulness in the installation of this memorial.

History and Incidence of Ureteral Injury

Injury to one or both ureters during operative procedures dates back to the initial days of pelvic surgery. Conger reports that Simon in 1869 performed a cutaneous ureterostomy following ureteral injury during an ovarian operation. Twenty-six years later Tuffner reported 40 cases of ureterovoginal fistula following vaginal hysterectomy. Since the beginning of the 20th century numerous others, mostly urologists, have published papers dealing with the incidence and treatment of such injuries.

A review of the literature indicates that accidental ureteral injury occurring in the course of pelvic or radical exenterating procedures has a reported incidence of one to three per cent. That the actual incidence of such injuries may be considerably higher is unquestioned for several reasons by such authors as Barrett, Bland, Eddy, Newell, and Patton.—D. Cramer Reed, M.D., Wichita, and A. I. Dodson, M. D., Richmond, Va.: *J. Kansas M. Soc.*, 58:8, August, 1957.

Considerations about Cesalpinus' and Harvey's Works on the Blood Circulation Discovery: A reprint of an article appearing in *Alcmaeon*, Journal of the History of Medicine. ($1.25. *Alcmaeon Publications, 217 E. 116th St., New York 29, N. Y.)* It is a review of the book by Professor G. P. Archieri, **The Circulation of the Blood** by Andrea Cesalpino of Arezzo. The original book can be obtained in English from S. F. Zanni, publisher and bookseller, 30 W. 12th Street, New York City. BP 193 illustrated. Published in 1945.

We American physicians who are not professional medical historians are apt to think of William Harvey in connection with the fundamental discovery of circulation of blood, a belief that has been fostered by most English texts on medical history. Cesalpino's description of the circulation, however, was published in 1571, some 57 years before Harvey's **De Motu Cordia** and had already appeared in a fourth edition prior to the time when Harvey reached Tadua.

William Harvey; His Life and Times—His Discoveries—His Methods, by Louis Chauvois. ($7.50, *Philosophical Library, New York 16, N. Y.)* This noted French scholar, long an admirer of William Harvey, has published many important papers on the history of European medicine. In this work he gives an account of Harvey's life and his relations with his contemporaries and re-examines the Latin text and suggests some current interpretations of Harvey's teaching are seriously at fault. He maintains that Harvey's line of thought, if properly understood and pursued in the light of modern knowledge, leads to some modifications of practical importance in the interpretation of the circulation of the blood.

Medical Professional Liability . . .

Highlights of Special Report on Subject, Based on Two-Year Study By AMA Law Department, and Presented Before the June 1957 Session

FOR the past two years, the Law Department of the American Medical Association has been making a study of medical professional liability. At the 1957 session of the AMA House of Delegates, a special report was presented.

Because of the widespread interest among the profession in this question and because of the interesting data revealed by the study, *The Journal* presents here in abstract form, some of the more important and more interesting facts and conclusions of the study.

It is hoped that all Ohio physicians will read this article carefully. In it they may find warning signals and specific suggestions for preventing threats and claims in connection with their own practice:

HIGHLIGHTS OF STUDY

Patients who have sustained an unsatisfactory result and are aware that they have not received best possible medical care as potential claimants. Where there is a poor medical result, merely fulfilling legal standards of care is sometimes not enough to prevent a claim. This usually is the case when the patient believes that the physician is not sufficiently sympathetic or if he considers the physician's fees to be excessive.

Professional liability cannot therefore be properly regarded as a legal problem exclusively. It is also a medical problem.

When effective means are discovered for reducing or minimizing medical professional liability problems it will be physicians who will lead the way by devising techniques that will minimize medical mistakes and patient dissatisfactions.

In the survey of individual physicians, 92.3 per cent said that they carried professional liability insurance and 92.6 per cent said that the insurance was not difficult to obtain. Of those answering the questionnaire 56.4 per cent expressed the opinion that the cost of professional liability insurance is reasonable.

There are at least 45 carriers writing medical professional liability insurance in the United States.

VALIDITY OF CLAIMS

Study of reported court decisions and the survey of physicians indicates that approximately 50 per cent of the claims and suits could not be sustained legally.

PROBLEM IS THAT OF ALL DOCTORS

Many physicians consider the problems of professional liability of academic interest. The fact is professional liability claims are not limited to a small group of "malpractice prone" doctors. Among the physicians who indicated they had experienced claims, 86.5 per cent incurred only 1 claim in their entire professional practice. Only 10.5 per cent of the physicians who reported claims had 2 claims in their entire professional practice; 1.9 per cent, 3 claims and 1.1 per cent 4 claims. Our figures indicate that professional liability is the problem of the many, not the few.

In a number of cases which were resolved in favor of the physician because of technical legal grounds it is possible that the verdict would have been against the defendant had the case been decided on its medical merits. On the other hand, there was a significant number of cases involving the doctrine of "res ipsa loquitur" (the thing speaks for itself) wherein the courts assumed negligence solely because there was no medical explanation for an unsatisfactory result.

SIGNIFICANT STATISTICS

Some of the significant statistics concerning professional liability claims as shown by the survey of physicians:

(1) 14.1% or approximately 1 out of every 7 physicians responding to questionnaire experienced professional liability claims during his professional medical career.

(2) 53.7% of those who have had claims said the claims were brought against them since 1950.

(3) 43% said the alleged act of malpractice occurred since 1950.

(4) Thirty-four years was the approximate median age of patient bringing the claim.

(5) 55% of the claimants were female, but 10 states had more male than female claimants, and 6 states had about the same number of female and male claimants.

(6) 72.5% of the physician respondents who had claims reported that they had personally performed the treatment or act of alleged malpractice.

(7) 67.2% of the incidents of alleged malpractice occurred in hospitals; 23.9% in the physician's office; 6.3% in the home of patient, and the remaining 2.6% occurred elsewhere.

(8) 30.9% of the claims involved surgery; 20.0% medicine; 19.7% orthopedics; 12.5% obstetrics and gynecology; 6.2% neuropsychiatry; 5.6% anesthesiology; the remaining 1.1% were either too small to tabulate separately or were not stated.

(9) The physicians who had 93.2% of the

claims reported that they had professional liability insurance.

(10) 28.9% of the physicians against whom claims were brought are certified by an American Specialty Board;

(11) 50.4% of the physicians against whom claims were brought stated that they were full-time specialists;

(12) Physicians experiencing claims said that they were in practice, on the average (median), about 13 years before they had a claim.

SOME SPECIFIC CONCLUSIONS

Some specific conclusions:

(a) An element which is present in all professional liability claims is dissatisfaction arising out of the physician-patient relations. Many of the cases which actually involved sub-standard medical treatment would probably not have matured into claims had it not been for some other cause of friction between the patient and the physician.

(b) Professional liability, although varying in severity in different localities, is a national problem which transcends local boundaries.

(c) The objective of the medical profession is not the prevention of professional liability claims as such, but the prevention of avoidable errors and omissions that result in injury to the patient and stimulate litigation, and the discouragement of unfounded claims.

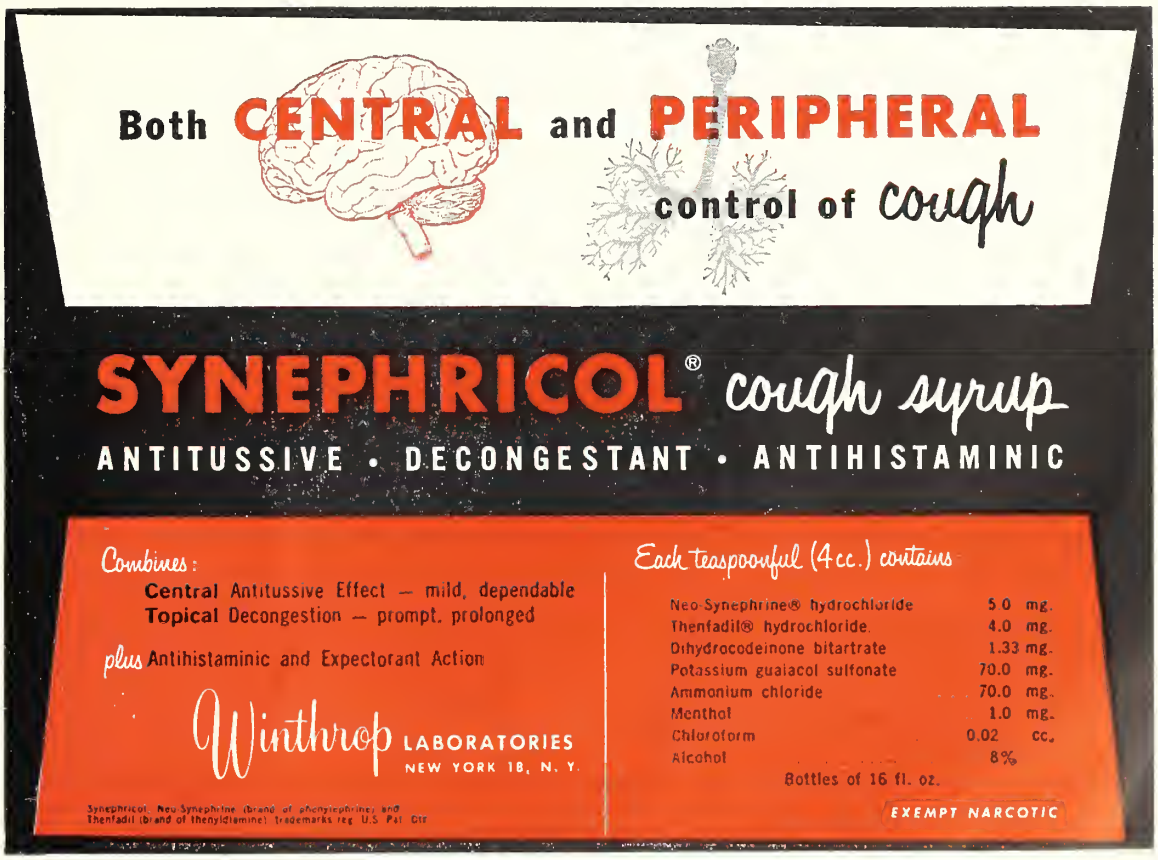
To implement this objective there is need for (1) an intensive educational program which emphasizes the nonmedical as well as the medical causes for professional liability claim, and (2) the utilization of the self-disciplining resources of the medical profession in the prevention of medical accidents within and outside the hospital.

(d) Regardless of the safety measures that are taken, the ever-increasing complexities of modern medicine create possibilities for human errors and omission even among the most qualified and experienced practitioners.

(e) In the interest of the public as well as the profession, physicians who have demonstrated that they are careless, incompetent or unethical in the treatment of patients should be dealt with effectively through medical society, state licensure and hospital disciplines to prevent the recurrence of patient injury.

(f) An effective educational and accident prevention program should include not only physicians, but physicians' employees and the hospital personnel for whose acts the physician may be responsible.

(g) An effective prevention program should include periodic examinations of equipment to avoid mechanical failures, and the abandonment of obsolete and defective devices.



Time To Give To AMEF . . .

Intensive Fall Campaign Will Urge Aid from the Medical Profession To Further Medical Education; Fund Chairman in Each County Named

THE American Medical Education Foundation will launch an intensive Fall campaign for contributions to the Nation's medical schools. October and November have been selected as the months for appeals to physicians for individual donations.

Dr. Merrill D. Prugh, Dayton, is chairman of the Ohio AMEF Campaign Committee, which is composed of the 11 District Councilors of the Ohio State Medical Association. Each county medical society has a local chairman.



M. D. PRUGH, M. D.

The AMEF was founded in 1951 by the American Medical Association to enlist the support of the medical profession in helping the medical schools to solve their financial problems. The National Fund for Medical Education was organized to solicit support from business and industry.

Since 1951, a total of $13,738,318 has been distributed to the schools in unrestricted grants for operating expenses. Approximately one-half of that amount was contributed by the medical profession.

The Ohio AMEF campaign is not in competition with the fund-raising efforts of individual medical schools and their Alumni Funds. The Ohio Committee hopes that physicians who have been contributing direct to their own schools will continue to do so. It wishes to point out that gifts made to the AMEF may be earmarked for a particular school. Such gifts will be added to the school's basic grants from unearmarked AMEF funds.

During the year 1956, a total of 39,892 contributors gave $1,072,727.00 to AMEF. In addition, contributions from 44,765 physicians directly to the Alumni Funds of their own medical schools amounted to $2,247,425.14, making a grand total of $3,320,152.14 donated by physicians to the cause of medical education during the year.

In 1956, there were 3,122 gifts from Ohio for medical education, 587 through AMEF, and 2,535 to medical schools through Alumni Funds. The AMEF total for Ohio amounted to $27,724.78. This amount includes $8,443.53 raised by the Woman's Auxiliary to the Ohio State Medical Association, for which the ladies received national recognition. Gifts from medical alumni located in Ohio directly to their own schools amounted to $113,527.92 in 1956, making the grand total of $141,252.70 donated by Ohioans for medical education during the year.

Dr. Prugh and the members of the Ohio AMEF committee hope that more Ohio physicians will respond generously in this year's campaign. They feel confident that the over 3,000 physicians who contributed to medical education last year, either through AMEF or directly to their own schools, will continue to do so. Also, they expect that more of their colleagues will assume a share of the responsibility for keeping the medical schools solvent and independent, under private auspices.

The initial appeal for contributions will be in a letter mailed soon to each member of the Ohio State Medical Association. This will be followed up locally by the county chairmen.

Following is a list of the county chairmen for the 1957 Ohio AMEF campaign:

FIRST DISTRICT

ADAMS—Herman P. Hyder, Bentonville
BROWN—Lyle C. Franz, Ripley
BUTLER—Elmer G. Sternberg, Hamilton
CLERMONT—John M. Coleman, Loveland
CLINTON—Robert M. Cronebaugh, Blanchester
HAMILTON—Stanley W. Whitehouse, Cincinnati
HIGHLAND—Leland Dale McBride, Hillsboro
WARREN—D. Paul Ward, Pleasant Plain

SECOND DISTRICT

CHAMPAIGN—Arthur B. Ream, Mechanicsburg
CLARK—Lillian M. Posch, Springfield
DARKE—Robert C. Prophater, Greenville
GREENE—Harvey B. McClellan, Xenia
MIAMI—Harold Carter, St. Paris
MONTGOMERY—R. Kent Finley, Sr., Dayton
PREBLE—A. L. Ross, West Alexandria
SHELBY—John H. Kerrigan, Sidney

THIRD DISTRICT

ALLEN—F. Miles Flickinger, Lima
AUGLAIZE—David W. Nielsen, Waynesfield
CRAWFORD—James E. Loggins, Galion
HANCOCK—John F. Loyd, Findlay
HARDIN—John A. Kramer, Ada
LOGAN—Hobart L. Mikesell, Liberty
MARION—Thomas S. Quilter, Marion
MERCER—Paul E. Beare, Celina
SENECA—Avery D. Powell, Tiffin
VAN WERT—S. A. Edwards, Van Wert
WYANDOT—S. R. Bame, Carey

FOURTH DISTRICT

DEFIANCE—George L. Boomer, Defiance
FULTON—Clarence F. Murbach, Archbold
HENRY—Richard L. Gilson, Napoleon
LUCAS—Martin W. Diethelm, Toledo
OTTAWA—Cyrus R. Wood, Clinton
PAULDING—J. H. Schaefer, Paulding
PUTNAM—Joseph J. McHugh, Ottawa
SANDUSKY—M. M. Riddell, Fremont
WILLIAMS—Russell K. Ameter, Bryan
WOOD—R. N. Whitehead, Bowling Green

FIFTH DISTRICT

ASHTABULA—Clarence T. Risley, Conneaut
CUYAHOGA—Milton E. Bobey, Cleveland
GEAUGA—S. Hayashi, Chesterland
LAKE—Howard Stephens, Mentor

SIXTH DISTRICT

COLUMBIANA—Paul W. Conrad, Leetonia
MAHONING—Harry A. Smith, Youngstown
PORTAGE—John S. Deyell, Ravenna
STARK—Blanchard V. Antes, Canton
SUMMIT—Henry H. Gibson, Akron
TRUMBULL—Louis A. Gleitsman, Warren

SEVENTH DISTRICT

BELMONT—Harry G. Harris, Martins Ferry
CARROLL—Glenn C. Dowell, Carrollton
COSHOCTON—Gerald A. Foster, Coshocton
HARRISON—James Z. Scott, Scio
JEFFERSON—C. W. Lighthizer, Steubenville
MONROE—A. R. Burkhart, Woodsfield
TUSCARAWAS—Samuel H. Winston, Dover

EIGHTH DISTRICT

ATHENS—Lawrence I. Goldberg, Athens
FAIRFIELD—Harold J. Schwendeman, Lancaster
GUERNSEY—Henry L. Wells, Cambridge
LICKING—Warren N. Koontz, Newark
MORGAN—Austin A. Coulson, McConnelsville
MUSKINGUM—Walter K. Chess, New Concord
NOBLE—Edward G. Ditch, Caldwell
PERRY—R. E. Herendeen, Jr., New Lexington
WASHINGTON—W. D. Turner, Marietta

NINTH DISTRICT

GALLIA—Oscar W. Clarke, Gallipolis
HOCKING—Owen F. Yaw, Logan
JACKSON—Tom Washam, Jackson
LAWRENCE—George Newton Spears, Ironton
MEIGS—Charles J. Mullen, Pomeroy
PIKE—Mack E. Moore, Piketon
SCIOTO—William J. Hartlage, Sciotoville
VINTON—Herbert D. Chamberlain, McArthur

TENTH DISTRICT

DELAWARE—James G. Parker, Delaware
FAYETTE—H. William Payton, Jeffersonville
FRANKLIN—L. Chandler Roettig, Columbus
KNOX—Henry T. Lapp, Mt. Vernon
MADISON—Robert S. Postle, London
MORROW—Andrew Maciurak, Cardington
PICKAWAY—Vermont D. Kerns, Circleville
ROSS—David McKell, Chillicothe
UNION—James W. Sampsel, Marysville

ELEVENTH DISTRICT

ASHLAND—John M. Strait, Ashland
ERIE—Dean E. Sheldon, Sandusky
HOLMES—Neven P. Stauffer, Millersburg
HURON—George F. Linn, Norwalk
LORAIN—Robert L. Adair, Lorain
MEDINA—Rodolfo F. Fasoli, Brunswick
RICHLAND—Robert L. Garber, Mansfield
WAYNE—F. C. Ganyard, Wooster

Ohio Physicians Are Certified in Obstetrics and Gynecology

Fifteen physicians in Ohio were among those recently certified by the American Board of Obstetrics and Gynecology, according to an announcement received from Dr. Robert L. Faulkner, Cleveland, Board secretary. A total of 302 throughout the country became diplomates of the Board.

Physicians in Ohio who received certification are the following: Drs. Daniel G. Cook, Lakewood; Conrad DeBold, Dayton; Quintin J. DeBrosse, Cincinnati; Joseph F. Downey, Cincinnati; Dorothy J. Hicks, Cleveland; Kay W. Kennedy, North Canton; Albert A. Kunnen, Dayton; Edward B. McGovern, Warren; Joseph P. Martin, Cleveland; George Mokris, Warren; Ernest M. Newkirk, Columbus; Richard J. Nowalk, Cleveland; Arthur G. Sartorius, Dayton; Joseph Schultz, Cleveland; and Royal M. Thomas, Euclid.

Several Ohioans Honored by Posts in Specialty Sections of AMA

Several Ohio physicians are among the specialty section officers of the American Medical Association as announced in the August 17 issue of *The Journal of the AMA*. Section officers were selected at section meetings during the Annual Session of the AMA in New York, June 3-7.

Following are Ohioans and the positions that they hold:

Dr. Kenneth C. McCarthy, Toledo, chairman of the Section on Anesthesiology.

Dr. Charles L. Leedham (Colonel, M. C., U. S. Army, Retired), Cleveland, re-elected delegate of the Section on Military Medicine.

Dr. Webb P. Chamberlain, Jr., Cleveland, nominated by the Section on Ophthalmology as one of three members, one of whom will be selected to serve on the Board of Governors of the American College of Surgeons for the term 1958-1961.

Dr. James I. Kendrick, Cleveland, representative to the Scientific Exhibit from the Section on Orthopedic Surgery.

Dr. Walter J. Zeiter, Cleveland, delegate of the Section on Physical Medicine.

Dr. Robert A. Kehoe, Cincinnati, vice-chairman of the Section on Preventive Medicine.

Dr. Frank Princi, Cincinnati, secretary of the Section on Preventive Medicine.

Dr. Paul A. Davis, Akron, representative to the Scientific Exhibit from the Section on Preventive Medicine.

Dr. Robert M. Zollinger, Columbus, elected to membership on the American Board of Surgery by the Section on Surgery, Abdominal and General.

Dr. E. F. Poutasse, Cleveland, assistant representative to the Scientific Exhibit from the Section on Urology.

Another honor won by an Ohioan was that awarded to Dr. David Volk, Western Reserve University School of Medicine, Cleveland, who was presented the $250 prize by the Section on Ophthalmology for the best exhibit. His exhibit was entitled Conoid Ophthalmic Lenses: An Original Development in Subnormal Vision Aids.

Toledo Center Will Be Converted To Children's Hospital

Opportunity Home for Crippled Children at 2740 West Central Avenue, Toledo, is being converted into a full-fledged hospital for the treatment of acute children's diseases, at a cost of approximately $100,000. It will provide a capacity of 62 pediatric beds and 18 convalescent beds.

Operated by the Toledo Society for Crippled Children, the hospital will continue its rehabilitation and convalescent program for children with crippling diseases.

INTRAVENOUS Compatible with common IV fluids. Stable for 24 hours in solution at room temperature. Average IV dose is 500 mg. given at 12 hour intervals. Vials of 100 mg., 250 mg., 500 mg.



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Many physicians advantageously use the parenteral forms of ACHROMYCIN in establishing immediate, effective antibiotic concentrations. With ACHROMYCIN you can expect prompt

INTRAMUSCULAR Used to start a patient on his regimen immediately, or for patients unable to take oral medication. Convenient, easy-to-use, ideally suited for administration in office or patient's home. Supplied in single dose vials of 100 mg., (no refrigeration required).

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control, with minimal side effects, over a wide variety of infections - reasons why ACHROMYCIN is one of today's foremost antibiotics.

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Medical Staff Meetings . . .

Importance of Regular Critical Review of Patient Care by Members Of the Profession Stressed by Joint Commission on Accreditation

BECAUSE the quality of patient care in the hospital can be improved only by a critical review of the work of the professional staff by the staff itself, there can be no compromise on the importance of regular staff meetings. The Joint Commission on Accreditation of Hospitals, in pointing out the purpose behind its policy, makes allowance for differences due to size of hospital, community in which it is located and other variations.

This is another in a series of articles based on bulletins issued by Dr. Kenneth B. Babcock, director of the Joint Commission on Accreditation of Hospitals. The article on Medical Staff Meetings follows:

* * *

From the start of the American College of Surgeons' hospital standardization program in 1918, the holding of regular medical staff meetings has been one of the standards on which approval of a hospital is based. In accepting the standards established by the College, the Joint Commission on Accreditation of Hospitals endorsed this principle as sound and essential for good patient care.

The sole purpose of hospital medical staff meetings is to improve the quality of patient care by means of a critical review and evaluation of the work of the professional staff. This analysis must be done by the medical staff, which should meet at frequent and regular intervals to accomplish this purpose.

Recognizing that differences exist in hospitals because of size, location, and medical staff organization, hospitals have a choice of one of the three following methods of fulfilling the medical staff meeting requirement:

1. **Monthly Meetings of Entire Active Medical Staff.** This method is particularly suited to the hospital of less than 75 beds which is not departmentalized. It is also well suited to the hospital where the medical staff is small and is organized to function as a committee of the whole.

2. **Monthly Departmental Meetings, and Quarterly Meetings of Entire Active Staff.** This method may be adopted when a hospital is well organized and departmentalized; and when found to be more effective than No. 1, above, for adequate and efficient review of the work of the staff. More frequent departmental meetings will depend upon the size of the hospital and the number of patients treated. Many hospitals find it advisable to hold weekly departmental meetings.

3. **Monthly or More Frequent Review of Clinical Work by Medical Records and Tissue Committees;** or by an audit committee which combines the functions of these two. In addition, monthly meetings of the executive committee of the medical staff and quarterly meetings of the entire active medical staff must be held. If conscientiously carried out, this method is effective in evaluating the quality of patient care.

Editor's Note: At the 1957 Annual Meeting of the OSMA, the House of Delegates instructed *The Journal* to publish material on hospital accreditation. The first article of a series on this subject appeared in the August issue, explaining the principles underlying the work of the accreditation commission. The second article in September dealt with recommendations of the AMA Stover Committee. This is the third article.

In subsequent articles *The Journal* will present suggestions and information from the Joint Commission on medical records and will present answers by the Commission to many varied questions on the activities of the Commission, standards set by the Commission, hospital administrative problems, etc.

Experience shows that one of these three patterns of medical staff meetings will fit any hospital seeking accreditation, whether it be small or large, rural or urban, affiliated with a medical school or not.

There is some confusion and misunderstanding between the medical profession and hospitals concerning the following aspects of hospital medical staff meetings:

1. **Frequency and Regularity of Meetings.** The regular monthly meetings,with not less than twelve in each calendar year, are necessary for adequate and effective evaluation of patient care. This means that such meetings should be held during the summer vacation months, for patients are treated in the hospital during these periods and their care should be evaluated.

2. **Multiplicity of Meetings.** Numerous complaints are voiced by the medical profession concerning the hardship of forced attendance at medical staff meetings of several hospitals to which they have appointments. This occurs because many physicians accept an impracticable multiplicity of active staff memberships. There is a growing feeling in the practicing profession that a physician should limit his active staff appointments to no more than two hospitals in order that he may best serve his patients and conserve his time and energy. If additional hospital facilities are desired by the physician, he may accept an associate, consulting, or courtesy staff appoint-

ment. Administration of the hospital should cooperate with the medical profession by making beds readily available to patients of physicians with other than active staff appointments.

3. **Combined Hospital Medical Staff Meetings.** In certain areas where the medical staff of two or more hospitals is identical, there may be a desire to combine the monthly staff meetings of the several hospitals into one time-saving meeting. This is not acceptable, for it defeats the prime objective of a medical staff meeting—evaluation of the care given patients in a particular hospital.

4. **Attendance at Meetings.** Adequate and effective participation in the evaluation of patient care requires regular, conscientious attendance at meetings of the active medical staff, departments or committees. It is expected that members of the active medical staff shall attend at least 50 per cent of these official meetings, unless excused by the executive committee of the medical staff for such exceptional conditions as sickness, absence from the community, or because of medical emergencies.

5. The Commission's standard on attendance at staff meetings pertains to the active medical staff members. It is the decision of the local hospital staff whether the attendance of associate staff members is required.

6. Departmental meetings and clinicopathologic conferences, although highly desirable and recommended, are not required by the Commission. These are requirements of the American Medical Association's Council on Medical Education and Hospitals for intern and resident training programs.

Remember, the Commission's requirements for medical staff meetings are the minimum for quality patient care. Many hospital staffs exceed these requirements and for this they should be commended.

Joint Commission Will Survey Mental Institutions on Request

A joint statement has been sent by the American Psychiatric Association and the Joint Commission on Accreditation of Hospitals to every mental institution in the United States and Canada announcing that after January 1, 1958, the Joint Commission would survey mental institutions on request. Mental institutions already on the accredited list published by the Joint Commission will automatically be surveyed at the proper time and notified in advance.

Mental institutions never previously surveyed should notify the Joint Commission of their desire for survey. Schedules of surveys are made up months in advance and any request should be in the hands of the Commission before January 1, 1958, to insure survey if possible for the forthcoming year. The Joint Commission's survey does not eliminate survey by the American Psychiatric Association if so desired and requested.

Ohio Society of Internal Medicine To Hold Second Meeting In January

Plans are being made for the second meeting of the Ohio Society of Internal Medicine in Cleveland on January 22, 1958, immediately preceding the Ohio Regional meeting of the American College of Physicians in that city. All Ohio internists who are members of the American College of Physicians or who have met the training requirements of the American Board of Internal Medicine may attend the meetings of the society.

The Ohio Society of Internal Medicine, which now has a membership of 110, was organized on May 13, 1957, immediately preceding the 1957 Annual Meeting of the Ohio State Medical Association in Columbus. As stated at that meeting, the aim of the society is to carry out the objectives of the American Society of Internal Medicine which are to secure and maintain the best patient care and the highest standards in internal medicine; also to create an organization to further the practice of internal medicine and to carry out research in the scientific, economic, social and political aspects of patient care.

At the organizational meeting, Dr. Arnoldus Goudsmit, Youngstown, was elected president; Dr. Geo. Hamwi, Columbus, vice-president, and Dr. Leonard P. Caccamo, Youngstown, secretary-treasurer. At the same time six councilors were elected. They are as follows: Dr. O. W. Clarke, Gallipolis; Dr. R. Franklin Jukes, Akron; Dr. J. Harold Kotte, Cincinnati; Dr. L. P. Longley, Shaker Heights; Dr. Maurice A. Schnitker, Toledo; and Dr. Joseph M. Wilson, Dayton.

Further information regarding the objectives and activities of the society is contained in the following statement issued by Dr. Clarke, who is public relations chairman for the society:

"One of the major objectives to be undertaken by this group is a clarification of the position of the internist in our present medical practice. It is recognized that Internal Medicine is a discipline based on advanced training and skills. This includes and adds to an ultimate thoroughness and coordination in the persuance of medical care. It is the feeling of the Ohio Society of Internal Medicine that internal medicine deserves recognition commensurate with other recognized specialties in medicine requiring an equivalent period of training and experience. It is hoped by the society that a service may be rendered to the internists of the state and the public at large by furnishing a comprehensible definition of an internist and his function in the broad field of medicine as practiced today. The society plans to act as a sounding board for the problems of Ohio internists in the scientific, economic, social and political aspects of his present-day practice. As stated in the objectives of the society, these previously mentioned objectives shall be brought in definite relationship to patient care."

Influenza Situation . . .

Statement of Policy Adopted by OSMA Council After Conference With State Director of Health Dwork: Some Questions Answered

A STATEMENT of policy on the influenza situation was adopted by The Council of the Ohio State Medical Association on September 14 at the regular Fall meeting of The Council in Granville.

This action was taken following a conference with officials of the Ohio Department of Health, including Dr. Ralph E. Dwork, director of the department.

PRIORITIES AND DOSAGE SCHEDULE

Among other things the statement endorsed the priority system for use of the influenza vaccine suggested by the Ohio Department of Health and the dosage schedule which has been recommended by the department. The dosage schedule suggested is as follows:

(1) Less than three (3) months of age—no vaccination.

(2) Three months to five years—one-tenth (0.1) cc. intracutaneously or subcutaneously, repeated after an interval of one to two weeks.

(3) Five to 12 years— one-half (0.5) cc. subcutaneously, repeated after an interval of one to two weeks.

(4) Thirteen years and older, the dose for adults—one cc. subcutaneously in a single injection.

SENT TO COUNTY SOCIETIES

Copies of the statement of policy have been transmitted to the officers of all County Medical Societies to assist them in handling the influenza situation locally and copies were sent to all Ohio news media.

Also, County Societies were supplied with a question and answer memorandum on the influenza vaccine to assist the local societies in answering questions from the public and physicians.

NO CASES UNDER MEDICARE

Some additional developments in the influenza situation are:

Private doctors operating under Medicare will not be authorized to give flu immunizations at government expense, but dependents may receive free inoculations at military hospitals and clinics. Explaining the policy, the Army's Office for Dependents' Medical Care said:

"Immunization for this disease is a procedure normally administered on an outpatient basis. Consequently, dependents, including those receiving obstetrical and maternity care, will not be eligible to receive influenza vaccine at Government expense, except as may be provided for in medical facilities of the uniformed services. A recent resolution of the State and Territorial Health Officers indicates that immunization for infants under three months of age is not recommended. Therefore, influenza vaccine for newborn is not authorized at Government expense. . . ."

Appended to this article is the complete text of the statement of policy and the question and answer memorandum:

STATEMENT OF POLICY ON INFLUENZA SITUATION AND IMMUNIZATION PROCEDURES GENERALLY

Evidence now in the hands of public health authorities indicates there may be an abnormal incidence of influenza throughout the nation this Fall and Winter.

Therefore, The Council of the Ohio State Medical Association recommends that each of Ohio's County Medical Societies should adopt a public information program on preventive measures and lay plans for combatting any influenza outbreak of serious proportions.

Standby programs which will be adopted in the various counties may have to vary (1) to meet the particular needs of the community; (2) to use to the best advantage existing local facilities and resources; (3) to comply with methods and techniques which the local medical profession deems best to meet local needs.

Although The Council believes there can be no stereotyped pattern for the entire state, it suggests the following general recommendations as the basis for local planning and action by the County Medical Society, assisted by other community groups where feasible:

1. A public information program to keep the public adequately and properly informed on the influenza situation should be inaugurated.

This should be a cooperative venture on the part of the medical society, local public health officials, local pharmacists and local news media.

As Surgeon General of the U. S. Public Health Service, Dr. Leroy E. Burney, has warned: "Any such campaign must be conducted in an orderly fashion to avoid confusion and hysteria in the public."

2. Physicians should be urged to keep themselves informed on the scientific and epidemiological aspects through articles published in *The Journal* of the American Medical Association and similar authentic publications.

Also, they should be requested to be prompt in reporting suspected influenza cases to the local

public health authorities so laboratory tests can be conducted to confirm the presence or absence of influenza in the community.

3. **Citizens should be encouraged to secure immunization against the prevalent strain of influenza from their personal physicians who are now able to secure the newly-developed influenza vaccine in limited quantities.**

The public should be advised that the supply of vaccine may be inadequate at present to meet public demand but larger quantities have been promised by drug companies during the next several months.

4. **The priority system for use of the vaccine recommended by the Ohio Department of Health and approved by The Council should be followed.** Under it the vaccine should be administered (a) to those whose services are necessary to maintain the health of the community; (b) to those necessary to maintain basic community services, i. e., utilities, communications, etc.; (c) to those with tuberculosis and others who constitute a special medical risk; (d) to the general public.

5. **The dosage schedule recommended by the Ohio Department of Health and publicized to local health departments is endorsed and recommended.**

6. **The best interests of the patient will be served if vaccination is done as a routine preventive medicine procedure in the office of each person's personal physician where, no doubt, the patient received immunization against other diseases, such as smallpox, diphtheria, polio, tetanus, etc.**

If this practice is followed (1) the hazards of mass inoculation will be avoided; (2) a permanent record of influenza immunization can be added to the medical information in possession of the patient's physician; (3) the problem of inequitable distribution of the vaccine can be minimized, whereas mass inoculation programs are likely to create a serious problem of mal-distribution of the available supply of vaccine.

Any plan which brings about mal-distribution will seriously conflict with community planning for the best use of the vaccine for the community as a whole.

7. **Local planning should include methods to assure that all persons in the community who desire to be inoculated with influenza vaccine will receive this service.**

8. **Distribution of the vaccine should take place through regular drug distribution channels.**

If necessary to assure equitable distribution among physicians of the community, plans for allocation of vaccine among physicians of the area should be developed on a community basis by the county medical society, local pharmacists and manufacturers of the new vaccine.

9. **Plans for local action in event a serious epidemic should occur should be drafted.** These should include:

(1) Ways of making full use of all physicians regardless of type of practice.

(2) An organized procedure for the use of other professional resources, such as nurses, nurses' aides, pharmacists, technicians, etc.

(3) Close coordination between physicians and the public health authorities on reporting of cases and utilization of diagnostic facilities.

(4) Possible revision of admission procedures for use of hospital facilities in event the hospitalization of large numbers of patients becomes necessary. Hospitalization of uncomplicated cases should be discouraged.

(5) Development of informative bulletins for both the public and the profession containing information on home-care of influenza victims; the supply of vaccine; why the antibiotics are known to be in general ineffective in virus infections and should be used with discretion, primarily to treat secondary bacterial infections which may develop in some cases; and other material designed to win the cooperation of the public and allay its anxiety.

10. **Even though planning to cope with an abnormal outbreak of influenza should be given priority at this time by the County Medical Societies, they, as well as the public, should not overlook the importance of continuous, local educational and preventive programs applying to all communicable and infectious diseases.**

County Medical Societies and local public health authorities should take inventory at this time on how well such programs are being handled; how much interest is being displayed in them by the public.

If the public is apathetic toward regular, routine immunization procedures, it should be alerted at once as to the value of such preventive measures which are today an integral part of the day-by-day practice of most physicians.

It should be noted that only a part of the job of immunizing those most susceptible to polio has been completed in most communities.

For that reason, it is suggested that all County Medical Societies map out plans this Fall and Winter for carrying on a follow-up public education campaign on polio immunization in cooperation with the public health authorities.

The public should be advised that polio vaccine is now in good supply making it possible for personal physicians to provide this service to those who have not started inoculations and those who should receive second or third inoculations.

Occasionally, special programs may have to be conducted to stimulate public interest in preventive measures against some particular disease.

However, in the final analysis a continuing program of public education in every community regarding the value of immunization procedures relating to all communicable and infectious dis-

eases is the most effective weapon which can be employed in the constant battle to minimize incidence of the preventable diseases.

QUESTIONS AND ANSWERS CONCERNING THE CURRENT INFLUENZA

The following material has been abstracted from reports on influenza from various authoritative sources, including the American Medical Association, the U. S. Public Health Service, and the American Academy of Pediatrics.

* * *

Q. Do most epidemiologists believe that the flu will reach epidemic proportions?

A. Yes, on the basis of experiences with past epidemics, the rapid spread of this influenza throughout the world, and the some 30,000 cases occurring in the U. S. between June 1 and August 31. This rapid spread is indicative of the fact that the disease is highly contagious.

Q. What is the incubation period?

A. The incubation period is one to three days, followed by rapid onset. The virus has an "explosion" characteristic which indicates that an epidemic could "explode" in a given city and be through its course in three to six weeks. The attack rate might be approximately 20 per cent of the population. This flu appears to attack all age groups equally.

Q. What are the symptoms?

A. Symptoms include rapid onset, high fever, chills, severe headaches, muscle aches, cough, cold symptoms, a sub-par feeling. A victim may have all or few of these symptoms. The flu lasts two to four days. It may be followed by a few days of sub-par feeling.

Q. How does the current flu compare with the one in 1918-1919?

A. Much less severe.

Q. Is the nation better prepared now to cope with a flu epidemic?

A. Yes. A specific vaccine is available. Antibiotics are available for secondary complications. In general, the people are believed to be in a much better nutritional condition, and should be more resistant to disease. Public health agencies are better organized to meet such emergencies.

Q. Should most flu cases be hospitalized?

A. Some cases will have to be. Many will want to be. However, chief reliance should be on home-care services by personal physicians and nurses. Hospitalization of uncomplicated cases should be avoided.

Q. What is the proper treatment?

A. "Symptomatic treatment." There is no specific treatment. Treatment should consist of complete bed rest, aspirin or other analgesics to relieve aches and pains. Antibiotics are not effective against flu but should be held in reserve to combat secondary complications, if any.

Q. What are doctors being asked to do if they suspect a flu epidemic in their community?

A. It is recommended that specimens be gathered from suspected cases in the first three days. Throat washings and paired sera should be submitted to a laboratory from at least 12 cases. Once the flu is identified, physicians may discontinue taking specimens and are advised to proceed to treat the situation as an epidemic. This will prevent overloading the laboratories.

Q. As cold weather approaches, may the flu be expected to increase?

A. Yes. While the reason is not definitely known, it is suspected that it is because people are indoors more and thus are more closely associated during cold weather.

Q. What is the principal concern regarding the current flu?

A. The real concern is the fact that in an epidemic community, 20 per cent of the population could be sick at one time, which could seriously affect basic and essential services of the community.

Q. Even though the virulence seems to be mild, could it become more severe?

A. There is no indication that the severity will increase. However, for the sake of preparedness, the possibility has not been entirely ruled out.

Q. Will the new vaccine prevent this flu?

A. On the basis of experiences in the military with past influenza vaccines developed to protect against other influenza virus strains, the vaccine is thought to be about 70 per cent effective.

Q. Does this mean that not everybody who receives the vaccine will be protected against the flu?

A. That is correct. For every 100 persons receiving the vaccine, it is expected that approximately 70 will be protected against this flu.

Q. Will the vaccine help a flu victim?

A. No—too late.

Q. Is the closing of schools, churches and theaters recommended if a flu epidemic occurs?

A. Most public health authorities agree that in past flu epidemics, closing has had no effect in limiting the spread.

Q. Will there be enough vaccine for everybody?

A. Not now. However, production by January 1, 1958 is expected to total 85 million doses. Ohio is expected to have about 4 million doses available by that time.

Q. What is the vaccine reaction experience?

A. Reaction, if any, is slight to moderate. However, since the vaccine contains egg protein,

persons allergic to egg protein should not be given this vaccine.

Q. How many inoculations should each person receive?

A. Public Health authorities suggest the following doses:

(1) Less than three (3) months of age—no vaccination.

(2) Three months to five years—one tenth (0.1) cc. intracutaneously or subcutaneously, repeated after an interval of one or two weeks.

(3) Five to 12 years—one-half (0.5) cc. subcutaneously, repeated after an interval of one to two weeks.

(4) Thirteen years and older, the dose for adults (one cc. subcutaneously in a single injection).

Q. How long does immunity last?

A. It takes 10 to 14 days after the shot to acquire immunity. Immunity should last 12 to 18 months. This is indicated by experiences with previous flu vaccines.

Q. Would a person who contracted the disease have the same period of immunity?

A. No. The immunity does not last as long as in other diseases. Re-vaccination at least once a year would not be superfluous.

Q. Is there a priority system for distributing the vaccine?

A. None. However, the drug manufacturers have been asked by the U. S. Public Health Service to allocate the vaccine to drug concerns and physicians in the various states according to population and on a weekly basis.

Q. How can a person get a vaccine inoculation?

A. He can get it in the same manner he gets any medical service—by going to his personal physician. The personal physician provides immunization services for other diseases as a matter of routine. Immunization against flu is no exception.

Q. Would a person immunized against other strains of flu virus be protected against this new strain?

A. No. The person would have to be given the new vaccine to be protected.

Q. Should there be a priority in vaccinating the public?

A. Public health authorities suggest that physicians give priority in vaccinations to (1) those whose services are necessary to maintain the health of the community; (2) those necessary to maintain other basic community services; (3) persons who are ill and whose illness makes them a special medical risk.

About 1,200 Medicare Bills From Ohio Physicians Being Paid Monthly

Information secured on August 26 from Mutual of Omaha which is administering the medical part of the Medicare Program in Ohio reveals that the number of bills submitted by Ohio physicians will eventually level off to approximately 1,200 monthly.

Following are statistics on claims involving physicians' services in Ohio for the period January 1 to August 20, 1957:

Month	Amt. Pd.	No. Claims
January	$11,754.30	144
February	39,625.16	584
March	59,357.65	816
April	70,213.19	1039
May	88,812.73	1155
June	77,840.28	1115
July	87,219.10	1183
August 1-20th	58,135.29	750
TOTAL	$492,957.70	6,786

Armed Forces Postpone Examination And Induction of Doctors

Dr. Drew L. Davies, chairman of the OSMA Military Advisory Committee, reported that he had received a bulletin from Selective Service entitled "Postponement of Armed Forces Physical Examination and Induction of Physicians and Dentists."

The communication, Operations Bulletin No. 181, dated August 19, reads as follows:

"1. The Department of Defense has informed this Selective Service Headquarters that it does not expect to place a call on the Selective Service System for physicians or dentists during the current fiscal year (ending June 30, 1958). Until such a call is received, action as prescribed hereafter in this bulletin shall be taken in the cases of registrants who are physicians or dentists. For the purposes of this bulletin a physician is any registrant who has received the degree of bachelor of medicine or doctor of medicine, and a dentist is any registrant who has received the degree of doctor of dental surgery or doctor of dental medicine.

"2. Whenever a registrant who is a physician or dentist is classified in a class available for service, the local board shall delay issuance of his Order to Report for Armed Forces Physical Examination (SSS Form No. 223) or cancel the order if it has been issued and the registrant's examination has not been accomplished, citing this bulletin as authority.

"3. Whenever a registrant who is a physician or dentist and who has had an armed forces physical examination is classified in a class available for service, the local board shall postpone issuance of his Order to Report For Induction (SSS Form No. 252) or cancel the order if it has been issued, citing this bulletin as authority."—

(Signed) Lewis B. Hershey, Director.

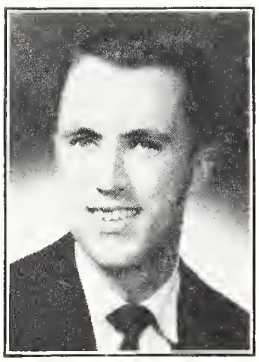
Rural Medical Scholarship Awarded . . .

Wayne County Youth Will Be Aided Through Medical School by OSMA Award: Program Is Geared To Stimulate Interest in Rural Practice

WINNER of the OSMA's ninth annual $2,000 Rural Medical Scholarship is 22-year-old William A. Hutchison of Smithville in Wayne County, who entered the Western Reserve University School of Medicine in September. Hutchison, a 1957 graduate of Wittenberg College, will receive $500 a year for each of his four years of medical school training.

A son of Mr. and Mrs. Virgil O. Hutchison, he was selected in statewide competition among rural medical students who entered medical school this Fall. He plans to become a rural physician when his medical training is completed.

Hutchison scored well in all of the five categories in which contestants are judged, those being character and integrity, interest in rural activities and organizations, leadership, scholastic ability, native intelligence and mature personality. He was highly recommended by officers of his local Farm Bureau, Grange, Wayne County Rural Youth, his church pastor, his county agricultural agent, high school and college officials.



WM. A. HUTCHISON

He graduated from Wittenberg cum laude. He worked to earn 80 per cent of his college expenses, receiving the other 20 per cent through scholarships. Since he was 16 years old, he has worked in a greenhouse, with the U. S. Forestry Service, in a slaughter house, as a painter, and as a hospital orderly, to achieve his education.

Instituted by the OSMA nine years ago, the scholarship is for the purpose of stimulating among young men and women from small communities and farms, interest in the study of medicine and a desire to practice in a rural area. The scholarship is administered by the Committee on Rural Health, Dr. E. K. Yantes, Wilmington, chairman. Serving as the special subcommittee to select the winner were Dr. H. R. Mayberry, Bryan, chairman; Dr. G. N. Spears, Ironton; Dr. L. W. High, Millersburg, and Dr. Kenneth Taylor, Pickerington.

Previous scholarship winners include (1956) Edwin L. Eakin, Canal Winchester, a sophomore at the University of Cincinnati College of Medicine; (1955) Ronald D. Moore, New Carlisle, a junior at the Ohio State University College of Medicine; (1954) M. Robert Huston, Millersburg, a senior at U. C.; (1953) Dr. Raymond Cole, Findlay, 1957 graduate of U. C.; (1952) Dr. J. Daniel Timmons, New Madison, Darke County; (1951) Dr. Donald Nikolaus, Johnsville, Morrow County, now in military service; (1950) Dr. Robert G. Smith, practicing medicine in Proctorville, Lawrence County, and (1949) Dr. C. Craig Wright, Winterset, doing postgraduate work at OSU College of Medicine.

The American College of Physicians Announces Fall-Winter Courses

The American College of Physicians has announced the following schedule of Autumn and Winter short courses:

"Mechanisms of Disease," October 7-12, University of Pittsburgh.

"Basic Concepts in Internal Medicine," October 14-18, Medical College of Virginia, Richmond.

"The Biological Approaches to Internal Medicine," October 21-25, University of Wisconsin Medical School, Madison.

"Recent Advances in Internal Medicine," October 28 - November 1, Tufts University School of Medicine, Boston, Mass.

"Cardiac Arrhythmias," November 1-3, University of Pennsylvania, Philadelphia.

"Current Research in Cardiovascular Disease," November 18-22, National Institutes of Health, Bethesda, Md.

"Gastroenterology," February 10-14, Duke University, Durham, N. C.

"Selected Problems in Internal Medicine," February 17-21, University of Southern California, Los Angeles.

Details may be obtained by writing: The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa.

Fully Accredited Hospitals Will Be Sent Pamphlets

Every hospital accredited by the Joint Commission on Accreditation of Hospitals for three years (full accreditation) has been sent a copy of the new pamphlet entitled, "You Can Have Confidence in Your Hospital." In the future, all hospitals that have been non-accredited or accredited for one year will be sent a copy when accreditation for three years has been attained. This pamphlet was prepared for hospitals to use as a device to explain to patients and the community what accreditation means.

Letter Sent to Governor . . .

The Council Requests That Efforts Be Continued To Find Solution For AFA Health Care Problem; Cooperation of Profession Offered

THE serious financial problem confronting the State Division of Aid for the Aged which caused the division to drastically curtail its health care program was thoroughly discussed on September 14 by The Council of the Ohio State Medical Association.

Taking part in the meeting were representatives of the Ohio Department of Welfare and officials of the Division of Aid for the Aged. Information regarding the situation which has been published in the *Ohio State Medical Journal* and in the *OSMAgram* was reviewed.

Reports were received on conferences which have been held by Governor C. William O'Neill and others which have been attended by representatives of the Ohio State Medical Association, called for the purpose of trying to find a solution for the situation confronting the division.

TEXT OF LETTER

By official action The Council instructed Dr. Robert S. Martin, the president, to write Governor O'Neill on this matter. Text of Dr. Martin's letter, dated September 16, follows:

The Honorable C. William O'Neill
Governor of Ohio
State House
Columbus 15, Ohio

Dear Governor O'Neill:

"I have been instructed by The Council of the Ohio State Medical Association to convey to you the sincere desire of the association to assist in every possible way in finding a solution for the serious problem which confronts the State Division of Aid for the Aged in relation to its health care program.

"The Council on the week-end of September 14-15 held an extended conference with Mr. Minor, assistant director of the Ohio Welfare Department, and officials of the Division of Aid for the Aged.

"Our board thoroughly understands the financial problem confronting the division which caused it to make drastic curtailments in the health care program. This has been reported by us to the medical profession of the state.

"Speaking for the physicians of the state, The Council regrets that the State of Ohio did not appropriate sufficient funds to meet the obligation which the state has assumed—namely to carry on an adequate health care program for the recipients of aid for the aged.

"The Council hopes that you and others in positions of authority will continue to exert every effort to correct this situation. The medical profession will support your efforts, you may be sure, as it is convinced that an adequate health care program for recipients of aid for the aged cannot be carried on under the existing financial setup and under the restrictions which have been placed on the program."

VIEWS OF LOCAL OFFICIALS

At conferences which have been taking place on this matter, representatives of the county commissioners and local relief authorities have stated that they will not be able to provide supplemental financial assistance for the Division of Aid for the Aged's health care program.

They point out that it was the understanding of local officials that the state would assume complete responsibility for the financing and administration of the AFA health care program and that local budget's for welfare purposes were compiled on that basis, namely, without provision for supplementation of AFA benefits.

Moreover, such officials have frankly stated that it is their belief that since the state has assumed the responsibility for the AFA program, the state should supply adequate funds for the program, including the health care program.

NEW DEVELOPMENTS

New developments in the Aid for Aged health care matter as this issue went to press were:

Ruling by Attorney General William Saxbe that providing medical and hospital care for the needy aged is a joint responsibility of the AFA (the state) and local relief agencies (cities and counties). The ruling points out that local relief agencies may continue to supplement medical and hospital relief provided by the state, as many of them have been doing in the past. Obviously, from a practical standpoint local relief agencies, like the AFA, would be limited by their budgets as to the amount of assistance given.

Governor O'Neill appointed a special committee to make a long-range study and recommendations regarding Ohio's aged citizens, including the programs of the Division of Aid for the Aged. The committee consists of heads of various state departments and commissions.

Among grants of the National Foundation for Infantile Paralysis for poliomyelitis respiratory and rehabilitation centers, is one to Children's Hospital, Columbus, in the amount of $82,754. The grant is one of 61 March of Dimes grants and appropriations announced by the Foundation totaling $4,527,064.

Licenses Granted . . .

As a Result of June Examinations. 359 Graduates of Medical Schools Are Issued Certificates by State Medical Board To Practice in Ohio

RESULTS of the examinations conducted by the State Medical Board of Ohio on June 13-15, were considered by the Board at its meeting on August 27, Dr. H. M. Platter, secretary, reported.

There were 403 graduates of schools of medicine who took the examinations and 62 graduates of osteopathic schools. In addition, in the limited branches, the following number of persons were examined: 20 chiropodists, 15 mechanotherapists, 56 chiropractors, 34 masseurs and 6 cosmetic therapists.

Certificates to practice medicine and surgery were awarded to 359 graduates of schools of medicine, and 55 graduates of osteopathy were authorized certificates to practice osteopathic medicine and surgery.

In the limited branches, 18 were awarded certificates to practice chiropody, 2 to practice mechanotherapy, 8 chiropractic, 15 massage and 4 to practice cosmetic therapy.

Three highest grades in the medical examinations all went to graduates of Ohio State University with a close margin of difference. Highest grade was made by Robert M. Hess, II, Findlay, with 89.4 per cent. Second highest went to Ivan L. Sandoz, Dayton, with 89.3 per cent, and third to James W. Funkhouser, Dayton, 89.1 per cent.

Following is the list of those issued certificates to practice medicine and surgery: (Where the present address and home town are different the home town is given in parantheses.)

OHIO STATE UNIVERSITY—Gene H. Abels, Augusta, Ga. (Columbus); Jerome S. Abrams, E. Cleveland; Donald J. Aiken, Toledo; William Allen, Colerain; Bartley E. Antine, Cincinnati (Cleveland); David G. Ashbaugh, Bucyrus; Milton E. Ashby, Akron (Lorain); Robert C. Austin, Jr., Englewood, Colorado (Dayton); Melvern A. Ayers, Toledo;

Robert O. Baab, Hilliards (Orrville); Allen Beallo, University Heights; Robert A. Beargie, Columbus (Rocky River); Nicholas C. Bellios, Akron; John Blackwood, Jr., Columbus (Sandusky); Joseph J. Bock, Columbus (Lakeville); William E. Bond, Columbus (Wakefield); Ralph D. Bradrick, Mansfield; John R. Brown, Alliance; Charles A. Burkhart, Lima (Youngstown);

Richard F. Cape, El Paso, Texas (Columbus); Charles G. Casey, Toledo; Samuel A. Chaney, New Athens; Beverly A. Collier, Detroit, Mich.; Richard L. Collier, Detroit, Mich. (Toledo); Frederick M. Cox, Caldwell; Robert I. Curry, Lima (Mansfield);

Eugene F. Dierksheide, Columbus (Pemberville); William E. Dozer, Zanesville; William B. Elderbrock, Toledo (Findlay); Lawrence R. Ellick, Akron; Robert J. Emrick, Honolulu, Hawaii (New Straitsville); Robert L. Epps, San Francisco, Calif. (Columbus); LeRoy J. Eulberg, Columbus (Toledo); Russell J. Eymann, Canton;

Alfred F. Fasola, Columbus; Harvey L. Fishman, New Orleans, La. (Dayton); David A. Fitz, Sandusky; William J. Fouty, San Diego, Calif. (Columbus); Thomas A. Fox, Jr., Akron; Myron W. Frederic, Philadelphia, Pa. (Akron); Marcus J. Freese, Dayton (Steubenville); James W. Funkhouser, Dayton;

Robert E. Garrison, Jr., Columbus; Theodore G. Goldfarb, South Euclid; Louis J. R. Goorey, Columbus; William R. Graham, Toledo (Edison);

Charles R. Harper, Columbus (Perrysburg); Beryl A. Harris, Toledo; Morton L. Harshman, Columbus (Youngstown); Charles T. Hay, West Jefferson; George T. Hensley, Toledo; Robert McDonald Hess, II, Findlay; Theodore A. Hufford, Atlanta, Georgia (Columbus); (John) Richard Hurt, Dayton (West Jefferson);

Lois A. Kachenmeister, Toledo; Leonard G. Katz, Shaker Heights (Cleveland); John H. Kennedy, Columbus (Granville); Donald R. Klein, Cleveland (Shaker Heights); Manfred E. Krause, Cincinnati; Frank W. Kroetz, Galveston, Texas (Tiffin); John L. Kuehn, Columbus (Toledo); Donald J. Kurlander, Cleveland;

Richard W. Lamprecht, Columbus; Milton J. Lenhart, Campbell; Gordon S. Leonard, Wellston; Joseph W. Leonard, San Francisco, Calif. (McComb); Leopold W. Like, New Bavaria; Edwin J. Lilly, Akron (London); James E. Lynsky, Lakewood;

George M. McClung, St. Louis, Mo. (Columbus); Robert D. Macmillan, Akron (Delaware); Robert E. Malone, Columbus; Morris J. Mandel, Cleveland; Roy E. Manning, Columbus (New Weston); Isadore Mendel, Columbus; George E. Mendell, Akron; William F. Mentges, Sidney;

Arnold M. Mitchell, Cleveland (Cleveland Heights); Duane V. Mohr, Tiffin; Frank M. Mowry, Findlay; Dale H. Myers, Cleveland;

Stanley H. Nahigian, Valley City; William F. Nichols, Columbus Grove (Belpre); Demetre M. Nicoloff, Lorain; Michael Ogden, Columbus; Henry C. O'Roark, Dayton;

Maesimund B. Panos, St. Petersburg, Fla. (Dayton); James R. Patterson, Denver, Colorado (Columbus); Donald A. Pensiero, Westlake (Cleveland); Francis E. Picklow, Cleveland; Hugh D. Pittman, Akron; John M. Pixley, Columbus; Peter

Press, Dayton; John T. Prince, W. Palm Beach, Florida (Toledo);

Barthalomew D. Ragucci, Columbus (Cleveland); Ruth H. Ragucci, Columbus; Ralph E. Rasor, Jr., Findlay; Jack S. Resnick, Akron; Daniel F. Reynolds, Jr., Pittsburgh, Pa. (East Liverpool); William C. Rigsby, Columbus (Warren); James J. Roda, Garfield Heights; Warren F. Rogers, Steubenville;

Ivan L. Sandoz, Galveston, Texas (Dayton); William E. Saneholtz, Napoleon; Victor Schiller, Philadelphia, Pa. (Akron); Robert G. Schwemley, Columbus; Robert W. Secrest, Columbus (Pleasant City); Wesley E. Shankland, Lima (North Royalton); James M. Shaw, Rocky River (Zanesville); Stanley H. Shensa, Youngstown; William H. Shriber, Akron; G. Nevin Shuey, Prospect;

Gilbert N. Silbiger, Akron (Cleveland) Louis H. Skimming, II, Columbus (Middletown); Darell J. Smith, Columbus (Zanesville); Robert L. Solt, Jr., Columbus (Bucyrus); David S. Spence, Eugene, Oregon (Columbus); Albert M. Starr, S. Euclid (Parma); Hyman M. Stockfish, Cleveland Heights); Nelson H. Stone, Cleveland Heights;

Stephan M. Ticich, Columbus (Cleveland); Donald E. Timmons, Long Beach, Calif. (Cadiz); Florin D. Treece, Columbus (Bloomdale); Richard C. Trump, East Cleveland (Cleveland);

John E. Venable, Jr., Lima (Thompson); Robert E. Visintine, Columbus (London); Michael J. Vuksta, Youngstown (Youngstown); Thomas M. Watkins, Ann Arbor, Mich. (Toledo); Joseph K. Welborn, Flint, Mich. (Columbus); Robert A. Williams, Jackson; Eugene R. Wynsen, Columbus (Youngstown); George J. Yobst, Ann Arbor, Mich. (Toledo); Charles G. Young, Columbus (Mansfield).

UNIVERSITY OF CINCINNATI — John W. Anderson, Tenafly, N. J.; Robert W. Ausdenmoore, Cincinnati; Louis Becker, Cincinnati; Marts E. Beekley, Sharonville; Robert T. Bliss, Cincinnati; Joseph G. Braum, Ft. Thomas, Ky.; Willard L. Brown, Jr., Canton;

Alan J. Camin, Chicago, Ill. (Dayton); Louis V. Castaldi, Ravenna (Powhatan Point); George A. Chiligiris, Cincinnati; Sidney Cohen, Cincinnati; Raymond M. Cole, Milwaukee, Wisc. (Findlay); Roger B. Cole, Shaker Heights; Stephen C. Cowdrey, Cincinnati; Leonard E. Cremer, Cincinnati;

Raymond Dann, Cortland; Delbert H. Dayton, Jr., Toledo; Cornelia M. Dettmer, Cincinnati; Rudolf Donath, Cincinnati; Bobby K. Ducker, Florence, Ky.; Ronald H. Fegelman, Cincinnati; Alan Freid, New Orleans, La. (Cincinnati);

Thomas E. Gaffney, Newtonville, Mass. (Cincinnati); Edward Genton, Norwood; Guy G. Giffen, Jr., Denver, Colorado (Dayton); Guy Charles Glenn, Parma; Germaine R. Hahnel, St. Louis, Missouri (Cleveland); Herbert Charles Hamel, Jr., Cincinnati (Haverhill, Mass.); Jack Hazen, Cincinnati; Ernest R. Hollabaugh, Ravenna;

Watkins F. John, Cincinnati (Lima); Robert K. Jones, Cincinnati (Oxford); Wallace A. Jones, Cincinnati (Dayton); Earl F. Jordan, Cincinnati; Donald R. Krabill, Cincinnati (E. Canton);

Allen Litwin, Cincinnati; James Magisano, Cleveland (Canton); Thomas T. McGranahan, Denver, Colorado (Lebanon); Martin C. McHenry, San Mateo, Calif.; Thomas H. Milby, Columbus (South Bend, Ind.); Roger C. Moyer, Kent; Thomas J. Mussio, Jr., Cincinnati; Paul Constantine Naturale, Ogden, Utah; Paul H. Nieberding, Oakland, Calif. (Cincinnati);

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Ralph G. Ratcliff, Cincinnati (Portsmouth); Walter C. Reesey, Jr., Girard; Edwin A. Roberts, Springfield; Harold R. Rubel, Cincinnati (Canton); David R. Rullman, Cincinnati;

Richard E. Sand, Cincinnati; David F. Schaefer, Cincinnati (Antwerp); Richard G. Schaefer, Cincinnati; Thomas McMaster Schlueter, Cuyahoga Falls (Akron); William McKay Sherk, Milwaukee, Wisconsin (Dayton); Loren T. Siefferman, Harrison);

Parker A. Small, Philadelphia, Pa. (Cincinnati); Alan J. Sogg, Shaker Heights; Richard J. Snyder, Sidney; James H. Spraul, Cincinnati; Norman M. Statman, Cincinnati; Paul D. Sweeney, Cincinnati;

Walter W. Timperman, Cincinnati; Abraham H. Topchik, Richmond, Va. (Passaic, New Jersey); Dwight T. Tuuri, Kent; Miles M. Vance, Hamilton; Dwanda L. Van Dyke, Los Angeles, Calif. (Long Beach, Calif.); John D. Veach, Cincinnati (Sciotoville);

Donald R. Weis, Cincinnati; Charles H. Wharton, Cincinnati; Newton B. White, Mason City, Iowa (Xenia); Harlan Williams, E. Portsmouth; Thomas J. Williams, Natalie, Pa.; Victor J. Wtek, Hartford, Conn., (Long Branch, N. J.).

WESTERN RESERVE UNIVERSITY—Robert G. Ainsworth, Lakewood; Robert E. Anderson, Cleveland Heights; Dwight J. Baughman, Ada; Allan G. Bennett, Rochester, N. Y. (Cleveland);

John R. Bovington, Euclid (Shaker Heights); Gerald F. Bowling, Cleveland (Akron); Blain S. Boyden, Cleveland (Koloa, Kauai, Hawaii); Charles C. Brausch, Avon Lake; Robert D. Brodell, Shaker Heights (Canton);

Theodore J. Castele, Cleveland; Boyd W. Cook, Chapel Hill, N. C. (Wooster); Thomas E. Driscol, Lorain; Richard T. Duback, Silver Spring, Md. (Cleveland); Theodore C. Eickhoff, Cleveland Heights; Robert T. Estes, Akron;

Fred L. Fisher, Jr., Cleveland; Walter R. Funk, Euclid (Berea); Saul M. Genuth, Shaker Heights; Bernard Givertz, Cleveland Heights; Earl R. Hackett, New Orleans, La. (Cleveland); Heber M. Halley, Jr., Cleveland; Shinichi Hamashige, Iowa City, Iowa (Kahuhu, Oahu, Hawaii);

Toby S. Helfand, South Euclid; Stanley Hersh,

Cleveland; Adams S. Hill, Jr., Cambridge, Mass.; Eugene Z. Hirsch, Cleveland;

Charles Elmer Inman, San Diego, Calif. (Cleveland); Roberta A. Irish, Cleveland; Pliny M. Keep, Cleveland (Galion); William G. Kenney, Rochester, N. Y. (Chagrin Falls); David E. Klein, Cleveland (Cleveland Heights); Irwin K. Kline, Cleveland Heights (Canton); Hazen G. Kniffin, Jr., Buffalo, N. Y. (Akron);

Martha Jean Leas, Cleveland; Daniel E. Leb, San Francisco, Calif. (Cleveland); Robert E. LeLievre, Cleveland (Shaker Heights); Allan L. Lemel, Shaker Heights; Jack R. Leonards, Cleveland; William K. Littman, Denver, Colo.; Richard W. Lomas, Lakewood; Oliver N. Lugibihl, Lima (Pandora);

Vincent T. Mannarelli, Cleveland (Erie, Pa.); Maxie C. Maultsby, Jr., Philadelphia, Pa. (Orlando, Fla.); Hermann Menges, Jr., Cleveland; Roger H. Michael, Cleveland (Sycamore, Ill.); David G. Miller, Cleveland Heights; Joseph A. Miller, Rochester, N. Y. (Washington, N. J.);

Burton S. Nelson, Jr., Toledo (Cleveland); Robert E. Nenad, Cleveland; James E. C. Norris, Kilmarnock, Va.; Charles E. Pope, II, Cleveland; Nicholas R. Popovich, Fairview Park (Cleveland); Edward W. Purnell, Euclid (Youngstown);

Elizabeth W. Rauschkolb, Shaker Heights (Cleveland); Perry G. Rigby, Lisbon; Joseph A. Ring, Cleveland (Bellaire); Uros Roessman, Cleveland; Robert S. Rosnagle, Cleveland Heights (London);

Albert Sattin, Cleveland (South Euclid); Henry A. Scali, Cleveland (Youngstown); Fredric M. Stoller, Shaker Heights; Franklin H. Swenson, Akron;

Richard M. Wahl, South Euclid (Cleveland); Theodore R. Warm, Durham, N. C. (New Philadelphia); Charles R. Webb, Jr., San Antonio, Texas (Cleveland); Robert A. Willits, Caro, Michigan (Cleveland); Mary M. Wolf, Cleveland (Marion, Ind.); Robert R. Kohn, Cleveland.

GRADUATES OF OUT-OF-STATE MEDICAL SCHOOLS (Alphabetically according to medical school)—Philip A. Khairallah, Cleveland, Columbia University; Donald E. Allen, Cincinnati (Lafayette), Cornell University; Elias T. Saadi, Youngstown, Georgetown University;

William H. Forrest, Jr., E. Cleveland, Hahnemann Medical College; James K. Fugate, Bainbridge, Md. (Sykesville, Pa.), Hahnemann; Donald H. Johnson, E. Cleveland, Hahnemann;

Charles T. Stewart, Cincinnati (Tacoma, Wash.), Harvard; Gerard E. Gurnick, Dayton, Loyola University; James B. Patterson, Lorain, Loyola; Richard S. Guy, Cleveland (Steubenville), Meharry Medical College; William H. Charlebois, Youngstown, New York Medical College; William J. Cleary, Jr., Youngstown, New York Medical College;

George R. Abbott, Cleveland (Lewisburg, West Virginia), Northwestern University; Helen F. Berquist, Youngstown, Northwestern; Edwin L. Cohen, Toledo, Northwestern; H. Allen Rankin, Springfield, Northwestern;

William T. Cook, Lakewood, University of Chicago; Theodore C. Sheftel, Cleveland (Scarsdale, N. Y.), University of Chicago; Howard M. Shelly, Bluffton, University of Illinois; James K. Loutzenhiser, Butler, Pa., University of Pittsburgh; William T. Martin, Youngstown, University of Pittsburgh;

William M. McKay, Jr., Dayton, University of Utah; James C. Pearson, Cincinnati (Seattle, Washington), University of Washington; Talivaldis Berzins, Columbus, Vanderbilt University; Antoinette J. Parisi, Youngstown, Woman's Medical College of Pennsylvania.

GRADUATES OF CANADIAN MEDICAL SCHOOLS—Hilaire Gaudreault, Cleveland Heights (LaMalbaie, Quebec), Laval University, Quebec; Michael V. MacInnis, Akron (Sydney, Nova Scotia), McGill University, Montreal; Louis Rakita, Cleveland (Montreal), McGill University; James J. I. Farmer, Akron (Ottawa), University of Ottawa; Jerry Drexler, Cleveland (Toronto), University of Toronto; Irving Stern, Cleveland (Toronto), University of Toronto; John R. Judge, Cleveland (Winnipeg, Manitoba), University of Manitoba.

GRADUATES OF FOREIGN MEDICAL SCHOOLS (Arranged according to country in which medical school is located)—Jordan Dentscheff, Chicago, Ill., Univ. of Vienna, Austria; Ernest Raab, Columbus, Univ. of Innsbruck, Austria; Demeter Skrypec, Minquadale, New Castle, Delaware, Univ. of Innsbruck; Walter Schnur, Cincinnati, Univ. of Melbourne, Australia;

George Barna, New York City, N. Y., Free Univ. of Brussels, Belgium; Michael K. Zylik, Detroit, Mich., Catholic Univ. of Louvain, Belgium; George I. Paprikoff, Chicago, Ill., Univ. of Sofia, Belgium;

Sister Joseph Ignatius Owyang, Cincinnati, St. John's Univ. of Shanghai, China; Gustavo Delgado, Cleveland, Univ. of Colombia, Bogota, South America; Raul Florez, Brockton, Mass., Nat. Univ. of Colombia, Bogota, S. A.;

Maria J. Colucci, 5034 W. North Ave., Chicago, Illinois, Univ. of Havana, Cuba; Angelica Maria Nunez, New York, N. Y., Univ. of Havana, Cuba; Alois Vasicka, Cleveland, Univ. of Brno, Czechoslovakia;

Ivan Dimitroff, Chicago, Ill., Univ. of Erlangen, Germany; Olga J. Dobrogorski, Cincinnati, Univ. of Erlangen, Germany; Algimaktas L. Cepulis, Cleveland (Marijampole, Lithuania), Univ. of Freiburg, Germany; Nadija L. Kuzma, Bryn Mawr, Pa., Univ. of Frankfurt-Main, Germany;

Charlotte V. H. Delhaes, 4111 E. 147th St., Cleveland, Univ. of Gottingen, Germany; Reinhard K. G. Marthen, Clayton, Mo., Univ. of Gottingen, Germany; Frank Mickevicius, Chi-

cago, Ill., Univ. of Gottingen, Germany; Herbert G. Birck, Columbus (Wiesbaden, Germany), Univ. of Heidelberg, Germany; David J. Samon, Cleveland Heights (Cleveland), Univ. of Marburg, Germany.

Vitalij Holonko, Youngstown, Univ. of Munich, Germany; Ivan H. Past, Cincinnati, Univ of Munich; Frida G. Surawicz, Burlington, Vt., Univ. of Munich; Sigismund Vechey, Asbury Park, N. J., Univ. of Munich; Rudolf Nowara, Tuxedo Park, New York, Univ. of Tugingen, Germany;

George D. Kanellos, Sanatorium, Texas, Univ. of Athens, Greece; Joseph F. Roh, Spokane, Wash., Univ. of Leiden, Holland; Raymond B. Cagnina, Mt. Vernon, N. Y., Univ. of Messina, Italy; Alexander L. Herland, Jersey City, N. J. (Bucharest, Roumania), Univ. of Milan, Italy;

Ivan G. Podobnikar, Warm Springs, Ga. (Montana), Univ. of Padova, Italy; Roland Burelli, Cleveland Heights, Univ. of Rome, Italy; Sara Lewin, Cincinnati, Univ. of Rome, Italy; Maria Garlo, Tiffin, Univ. of Kaunas, Lithuania;

Jonas Zemaitis, Kalamazoo, Mich., Univ. of Kaunas; Joachim G. Elizondo, Trenton, N. J., National Univ. of Mexico; Charles Escudero, Cleveland, National Univ. of Mexico; Edward Z. Schmidt, Cincinnati, Univ. of Nuevo Leon, Mexico; Julio A. Ayulo, Cincinnati, National Univ. of San Marcos, Peru; Pedro E. Zamora, Aguadilla, Puerto Rico, Univ. of Puerto Rico; Borys G. Andriewsky, Waynesburg, Charkow Med. Ins., Russia;

Irving Friedman, Brooklyn, N. Y., Univ. Basel, Switzerland; Robert Krasnow, San Francisco, Calif. (New York City, N. Y.), Univ. of Geneva, Switzerland; Milton B. Myers, Baltimore, Md. (Columbus), Univ. of Geneva; Irwin Menachof, Cincinnati, Univ. of Lausanne, Switzerland; Jonathan B. Greenberg, South Euclid (Cleveland), Univ. of Zurich, Switzerland; John O. Odabashiam, Cambridge (Lehighton, Pa.), Univ. Istanbul, Turkey.

New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since August 1, 1957. The list shows the County in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

COSHOCTON COUNTY

Myron Saturski, Newcomerstown

CUYAHOGA COUNTY

Dolores-Crystal Arnois, Cleveland

FAYETTE COUNTY

Edwin R. Davis, Jeffersonville

MAHONING COUNTY

Herman L. Allen, Youngstown
Donald R. Bernat, Youngstown
Robert G. Warnock, Youngstown

PORTAGE COUNTY

George R. Sprogis, Hiram

SUMMIT COUNTY

Warren P. Kilway, Jr., Cuyahoga Falls

TUSCARAWAS COUNTY

Roy Geduldig, Dover
James F. Zeller, New Philadelphia

WILLIAMS COUNTY

Melmoth Y. Stokes, III, Edon

Doctor's Orchestra of Akron Goes Into 32nd Season

The Doctor's Orchestra of Akron in September began rehearsals for its 32nd Season.

It was organized in 1926 by its present director, Dr. A. S. McCormick, and has given 200 concerts in 11 cities of Ohio, for 33 hospitals and other institutions and organizations. Eight concerts have been benefits for the City Hospital of Akron, St. Thomas Hospital, Wadsworth Municipal and Barberton Citizens Hospital. The orchestra played in 1927 in Columbus for the Ohio State Medical Association.

The orchestra, numbering 41 members, will rehearse until February in which month it will begin its series of concerts.

Veterans Administration Announces Clinical Conference Series

The Veterans Administration, Cleveland Regional Office, has announced a series of conferences to be held in Cleveland, beginning in September and running through January. The conferences under chairmanship of Dr. Charles Berns will be held on Wednesday evenings (with one exception) in the conference room, 7th Floor, Cuyahoga Building, from 8:00 to 9:00 p. m. Topics for future meetings are as follows:

October 9—**Virus Disease**, Dr. R. E. Bowman.

October 16—**Oral Malignancies**, Dr. W. J. McGill.

October 23—**Neuropathies and Radiculopathies**, Dr. Harry N. Roback.

November 8 (Friday)—**Arthritis**, Dr. Richard T. Smith of Merck Sharp & Dohme.

November 13—**Edge of Silence** (film of interest to hard of hearing persons), Dr. Charles Berns.

November 20—**Tumors of the Eye**, Dr. J. J. Berry.

December 4—**Social Service**, Francis P. Straub.

December 11—**Postgastrectomy Syndrome**, Dr. W. Parker.

December 18—**Surgical Aspects of Arterial Vascular Disease**, Dr. M. P. McKinley.

January 8, 1958—**The Tranquilized Veteran**, A Panel Discussion, Dr. H. Curtis and clinical psychology staff.

January 15—**Role of Physical Medicine in Chronic Illness and Geriatrics**, Dr. R. Lowry.

January 22—**Parkinsonian Syndrome**, Dr. Rose Herman.

January 29—**Diabetes Mellitus**, Dr. Edward Schwartz.

The AMA's Council on Industrial Health will co-sponsor a session on "Vision in Industry" with the American Society of Safety Engineers and the National Safety Council's occupational health nursing section on October 24 at the National Safety Congress, Congress Hotel, Chicago.

FALL POSTGRADUATE COURSES—ORGANIZATIONS ARRANGE EXCELLENT PROGRAMS IN VARIOUS PARTS OF STATE

District Societies have arranged some excellent Fall programs for physicians of their respective areas, and other organizations have scheduled postgraduate courses on current topics of interest. A number of these programs were reported in detail in the September issue of *The Journal*. The reader is referred to these programs on pages 1044 to 1047 of that issue, which included the following events:

October 3—Eighth Councilor District Program, Washington County Country Club, Marietta, program early afternoon preceded by golf tournament.

October 5—Columbus Academy of Medicine Clinic Day, Veterans' Memorial Building, Columbus, beginning 9:45 a. m.

October 9—Montgomery County Medical Society Founders' Day and Second District Meeting, dinner and evening program, Biltmore Hotel, Dayton, preceded by afternoon clinic.

October 23—Sixth Councilor District Postraduate Day, morning and afternoon sessions and evening meeting, Onesto Hotel and YMCA, Canton.

October 23—Northwestern Ohio Medical Association Annual Meeting, Auditorium of Defiance College, Defiance, 9 a. m. to 4 p. m.

Additional programs announced in this issue include those sponsored by the following: Veterans Administration Clinical Conference Series, Cleveland; Frank E. Bunts Education Institute, and the Central Ohio Heart Association.

Battelle Institute Announces Research Program in Psychochemistry

Studies now under way at Battelle Memorial Institute in Columbus are aimed at increasing the understanding of relationship between the chemical structure of certain substances in the field of the tranquilizing drugs and the nature of their effects on the brain.

The four functional groups of greatest interest in this study are the vicinal trimethoxy linkage, diethylamide grouping, indole nucleus and the urethane residue. They are found variously in such compounds as LSD, adrenochrome, mescaline, resperpine and barbiturates.

Conducting the study is a group of chemists who are working under a grant from the National Institute of Mental Health. Dr. Richard D. Morin will conduct the investigation in collaboration with Dr. Frederick Benington and Dr. Edward L. Kropa.

Animal experimentation will be in collaboration with Dr. Leland C. Clark, of the Fels Research Institute, Yellow Springs. Advanced stages of the study will be done in cooperation and consultation with representatives of the Ohio State University College of Medicine and the Columbus Receiving Hospital.

Bunts Institute Announces Two Scheduled Courses

The Frank E. Bunts Educational Institute, affiliated with the Cleveland Clinic, has announced two courses, one entitled "Current Trends in Hematology," October 23 and 24, and the other "Clinical Chemistry Methods," November 13-15.

The course "Current Trends in Hematology," will be presented by staff members of the Cleveland Clinic Foundation, assisted by several guest speakers, Wednesday and Thursday, October 23 and 24. A courtesy luncheon will be served on Wednesday. Registration is $20 except for interns, residents and members of the Armed Forces in uniform, who will be admitted free. Registration is limited to 125.

The symposium on "Clinical Chemistry Methods," is scheduled Wednesday - Friday, November 13-15. Special attention will be given to electrophoresis, liver function tests, enzyme tests and microanalysis. The program is of interest to the clinical chemist and the clinical chemistry laboratory supervisor. Registration fee is $15 with the same exceptions noted before.

Details of these program may be obtained by writing: Registrar, The Frank E. Bunts Education Institute, 2020 East 93rd Street, Cleveland 6.

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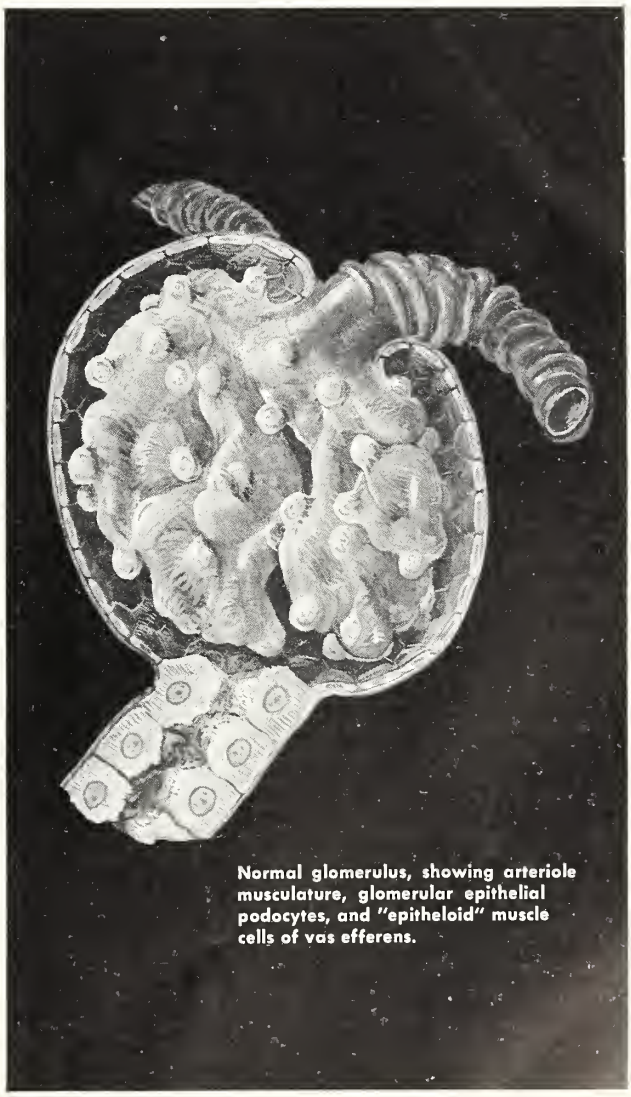
The low incidence of side action with Rolicton (brand of amisometradine) permits high dosage, extending the range of effective diuresis to a greater number of patients than was previously possible.

Laboratory studies demonstrate that Searle's new oral diuretic, Rolicton, causes positive diuresis with an essentially balanced excretion of water, sodium and chlorides.

Settel[1] studied the effect of Rolicton in forty-seven patients and found no serious side effects. Assali, who observed the action of Rolicton in five patients with severe toxemia of pregnancy, states[2] that side actions are essentially nonexistent. Side actions of such low incidence, together with its diuretic efficacy, suggest a high order of usefulness for Rolicton.

One tablet of Rolicton, b.i.d., is usually adequate to maintain patients free of edema after the first day's dosage of four tablets. Some patients respond well to one tablet daily. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

1. Settel, E.: Rolicton® (Aminoisometradine), a New, Nonmercurial Diuretic, Postgrad. Med. *21*:186 (Feb.) 1957.
2. Assali, N. S.: Personal communication, May 28, 1956.



Normal glomerulus, showing arteriole musculature, glomerular epithelial podocytes, and "epitheloid" muscle cells of vas efferens.

SEARLE

New Food, Drug and Cosmetic Act . . .

Became Effective in Ohio on September 13. Taking Place of Old Statutes Which Were Inadequate: Provisions of New Law Explained

OHIO has a new and modern Food, Drug and Cosmetic Law. Amended House Bill 667, enacted by the recent General Assembly, became effective on September 13. It is patterned after the model, uniform act now in effect in approximately 20 states.

The new statute is designed to prevent the manufacture and sale in Ohio of adulterated and misbranded devices used in the diagnosis or treatment of disease, and drugs, foods and cosmetics.

Administration and enforcement are shared by the State Board of Pharmacy and the State Department of Agriculture. The Ohio Public Health Council is given some rule-making and advisory authority in connection with sections of the law relating to drugs and devices.

Penalties are provided for false or misleading advertising of foods, drugs, devices or cosmetics.

EXEMPTS PHYSICIANS

The law specifically states that the provisions of the act do not apply to or prohibit the administering or dispensing of a drug or device by physicians in good faith in the course of professional practice, except with respect to any "new drug" which must have received official state or Federal approval before it may be administered or dispensed.

The new Ohio law takes the place of statutes which were enacted as long ago as 1886 and which have been found to be inadequate to meet modern conditions.

DEFINITIONS

Following are certain definitions set up in the act which will be of interest to physicians:

"'Drug' means (a) articles recognized in the official United States Pharmacopoeia, official Homoeopathic Pharmacopoeia of the United States or official National Formulary, or any supplement to any of them; and (b) articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals: and (c) articles, other than food, intended to affect the structure or any function of the body of man or other animals: and (d) articles intended for use as a component of any article specified in clause (a), (b), or (c) of this paragraph: but does not include devices or their components, parts, or accessories.

"'Device,' means instruments, apparatus and contrivances, including their components, parts and accessories, intended (a) for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals; (b) to affect the structure or any function of the body of man or other animals.

"'New drug' means: (a) any drug the composition of which is such that such drug is not generally recognized among experts qualified by scientific training and experience to evaluate the safety of drugs, as safe for use under the conditions prescribed, recommended, or suggested in the labeling thereof; or (b) any drug the composition of which is such that such drug, as a result of investigations to determine its safety for use under such conditions, has become so recognized, but which has not, otherwise than in such investigations, been used to a material extent or for a material time under such conditions."

ADVERTISING CONTROLS

The section on advertising reads as follows:

"Sec. 3715.68. (A) An advertisement of food, drug, device, or cosmetic is false if it is false or misleading in any particular.

"(B) For the purpose of sections 3715.01 and 3715.52 to 3715.72, inclusive, of the Revised Code, the advertisement of a drug or device representing it to have any effect in albuminuria, appendicitis, arteriosclerosis, blood poison, bone disease, Bright's disease, cancer, carbuncles, cholecystitis, diabetes, diphtheria, dropsy, erysipelas, gallstones, heart and vascular diseases, high blood pressure, mastoiditis, measles, meningitis, mumps, nephritis, otitis media, paralysis, pneumonia, poliomyelitis (infantile paralysis), prostate gland disorders, pyelitis, scarlet fever, sexual impotence, sinus infection, smallpox, tuberculosis, tumors, typhoid, uremia, venereal disease, is also false, except that no advertisement not in violation of subsection (A) is false under this subsection if it is disseminated only to members of the medical, dental, pharmaceutical or veterinary profession, or appears only in the scientific periodicals of these professions; provided, that whenever the director determines that an advance in medical science has made any type of self-medication safe as to any of the diseases named above, the director shall propose for adoption by the public health council by regulations authorizing the advertisement of drugs having curative or therapeutic effect for such disease, subject to such conditions and restrictions as the director may deem necessary in the interests of public health; provided, that this subsection shall not be construed as indicating that self-medication for diseases other than those named herein is safe or efficacious."

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Ascorbic Acid	30 mg.	Manganese	1 mg.
B-12	1 mcg.	Magnesium	5 mg.
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Cobalt	0.1 mg.	Potassium	2 mg.
Copper	0.2 mg.	Zinc	1 mg.
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Vitamin E	1 I.U.	Inositol	20 mg.
Cal. Pantothenate	3 mg.		

Write for Latest Technical Bulletins.

*REFERENCE: J.A.M.A. 163: 359, 1957 (February 2)

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Prophenpyridamine Maleate	12.5 mg.
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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

ETHICS AND MAILING OF REPRINTS

Did you ever wonder whether or not an ethical question might be involved in the matter of distribution of reprints?

The Judicial Council of the AMA, the responsibility of which is to interpret the Principles of Medical Ethics, received this question:

"May I ethically mail reprints of articles written by myself and published in national or state medical journals to members of the medical profession?"

Here is the answer made by the Judicial Council:

"One normally would not take it upon himself to mail reprints indiscriminately without sufficient reason. What constitutes a sufficient reason is impossible to define categorically. Certainly it would not be ethical for a physician to mail reprints if his intent was to solicit patients directly or indirectly or to attempt to bring undue attention to himself. The practice, therefore, cannot be recommended. This is not to say that the author of a medical article may not honor requests for copies of his article."

NEW DRUG LAW A STEP FORWARD

Ohio's new food, drug and cosmetic act became effective on September 13. It has many commendable provisions. See the article about it in this issue, on page 1188.

According to newspaper stories the manufacturing of drugs at Ohio Penitentiary for use in various state institutions and state agencies will be stopped unless the provisions of the new state law are complied with. There is doubt if that can be achieved.

Therefore if the law accomplishes nothing but this (but, of course, it has many additional good features) it will be a step forward as certainly the state has no business being in the drug business. Much additional progress in preventing the adulteration, misbranding and misleading advertising of drugs and medicines in Ohio should result.

DON'T COUNT ON FANATICS GIVING UP

Those who may have followed the course of H. B. 384, the bill to make abandoned dogs available for medical research and teaching, through the Ohio General Assembly to its final enactment (effective date being September 13), were amazed, no doubt, at some of the statements made in the press and on the air by some of the opponents. The experience revealed just what medical scientists and teachers are confronted with in the form of bitter and ruthless combat on the part of those who oppose vivisection.

That there will be no letdown in the dogged opposition on the part of the fanatical group which opposed H. B. 384 is evidenced by the following statement quoted from the August-September issue of The National Anti-Vivisection Society, located in Chicago and, believe it or not, at 542 N. Dearborn Street, practically next door to the AMA at 535 N. Dearborn:

"Despite the valiant fight waged by the Anti-Vivisection Society of Ohio from the very day it was introduced, Ohio's dog seizure bill was passed by the legislature, signed by the governor and now is a law of the state. An amendment to permit humane societies to refuse dogs to the vivisectors was beaten. Although defeated, anti-vivisectionists succeeded in focusing the attention of millions of residents of the state on the issue and hundreds of thousands of words, pro and con, were printed about the bill in scores of newspapers throughout the state. Our one, big need is numerical strength, without which we must expect legislative setbacks. As the societies grow, slowly but surely, the day will come when our voice will be important in legislative halls and then the tide will turn."

PRIVILEGE TO SET FEE CAN BE ABUSED

In his President's Page in the Columbus Academy of Medicine Bulletin, Dr. Norman O. Rothermich discusses medical fees and public relations. He makes the following excellent point which every physician should heed:

"The autocratic position and right of self-determination of each physician in managing his own office and setting his professional fees is jealously guarded and encouraged by the medical profession, but this privilege can be abused by the individual physician when it reflects unfavorably on his colleagues and the profession as a whole."

MOVE ON FOR MEDICAL CARE IN SOCIAL SECURITY SYSTEM

Washington prognosticators are predicting further expansions in the Social Security System in 1958—an election year. That is becoming the habit with the politicians.

Of interest are the following comments by one well-known Washington observer:

"New kinds of benefits also are likely to come under consideration. Medical care, for example. This has long been a dream of liberals and next year may be the year that it gets started. The

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ANESTHESIOLOGY

A three months full time course covering general and regional anesthesia with special demonstrations in the clinics and on the cadaver of caudal, spinal, field blocks, etc.; instruction in intravenous anesthesia, oxygen therapy, resuscitation, aspiration bronchoscopy; attendance at departmental and general conferences.

DERMATOLOGY AND SYPHILOLOGY

A three year course fulfilling all the requirements of the American Board of Dermatology and Syphilology. Attendance at departmental and general conferences.

COURSE FOR GENERAL PRACTITIONERS

Four weeks intensive full time instruction covering those subjects which are of particular interest to the physician in general practice. Fundamentals of the various medical and surgical specialties designed as a practical review of established procedures and recent advances in medicine and surgery. Subjects related to general medicine are covered and the surgical departments participate in giving fundamental instruction in their specialties. Pathology and radiology are included. The class is expected to attend departmental and general conferences.

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SEARLE *Research in the Service of Medicine*

present proposals are limited to hospital, surgical and nursing-home service for all persons eligible for retirement benefits . . . but no regular physician's services. Note, eligible would also include workers over 65 who are not retired. There is a strong feeling that this is the social welfare area of greatest unmet need. Medical insurance rates are so high for over-65's that most of them are unable to afford it. Gov't is only alternative. But this is also area of greatest controversy. Doctors and other groups are opposed to it . . . for socialized medicine. Watch for a bitter fight."

Suggestion: Discuss this with the candidates for Congress from your district before the Congressional elections next year.

ELECTIONS ARE ALL-IMPORTANT DESPITE SO-CALLED "OFF-YEAR"

There will be an election November 5. The polls will be open, somebody will be elected and communities will be made better or worse.

Municipal elections are important to people in the municipalities. Township elections are important in those townships involved. Boards of education are all-important to the future of the community.

By no means incidentally, there are a few state-wide issues involved. One-third of the members of the new State Board of Education will be elected this year. Three proposed Amendments to the State Constitution will be on the ballot. There may be a fourth, depending on action of the State Supreme Court in regard to the proposed amendment that would provide unlimited sale of water and sewage services by municipalities.

It is true, there is no president to elect this year, nor senators, nor representatives, nor governor. But most physicians are more interested in what goes on in their own communities than they are in Washington.

There are no "off-years" when it comes to elections. If there is an election in your community, there are issues and personalities involved. These issues and candidates deserve the personal attention of every physician who is within the realm of influence.

SHOULD BE A MEMBER REGARDLESS OF STATUS

The AMA says that as of December 31, 1956, of the 229,876 doctors of medicine in the United States, 32 per cent or approximately 72,000 are not in private practice but are in government service, employees of industry, in internship or residency, in health departments or hospitals, engaged in teaching or research, handling administrative details, etc.

In an editorial on this *The Journal of the AMA* made these mighty timely and important comments and recommendations which, in our opinon, should be heeded not only by the non-private-practice physicians but by medical organizations as well:

"Just how many of these medical doctors are members of their local medical societies is not known, but it should be emphasized that their participation in all medical society activities of an economic or organizational nature is important. Medical policies concerning patient care, as well as the 'politics' of health, begin at the county society level, and, if all physicians can participate in some way in such activities, there may be less misunderstanding and more cooperation to the benefit of all in the future. After all, the majority of the 35,000 interns, residents, and reserve medical officers will probably enter 'private practice' as soon as their present obligations are fulfilled.

"One group of nonpracticing physicians extremely important to organized medicine is the full-time teachers in medical schools. These men and women have a tremendous influence in orienting future physicians toward medical policies of tomorrow. In addition, much of the research that will directly affect future patient care is supervised through medical centers connected with medical schools.

"If local and state medical organizations invite the participation of the nonpracticing physician, such participation is a two-way proposition. This same non-practicing physician to obtain a voice in organized medicine should be willing to become an active, not absentee, member of his local medical society. What it really amounts to is that every doctor of medicine should be a part of, not apart from, his officially recognized medical organization."

FITNESS IDEA SHOULD NOT BE OVERINFLATED

In our opinion the editorial in the September, 1957, issue of *The Journal of the AMA*, entitled, "Fitness of American Youth" was a ten strike. It laid it right on the line. Read it, as no doubt you've been reading in the press that the Federal Government is organizing a youth fitness program with all the trimmings.

The editorial expressed the need for medical interest in this question and encouraged all physicians, individually and through their medical societies to show their willingness to participate in the community action along these lines.

At the same time it set down certain fundamentals which should be observed in attaining the end. It spoke on competitive sports. It rapped the fallacious use of examination statistics from draft registration as a measure of health. Indirectly it spanked those who have been yelling loudly about decadency of American youth.

In the closing paragraph, from which the following is quoted, a firm and sensible position for the medical profession to take is outlined:

"The medical profession may be counted upon as always to give its wholehearted cooperation to any worthy project embraced in the President's broad program for the fitness of American youth. By the same token, the medical profession will speak out without fear against any unsound proposals or against any movements which are wasteful, duplicating, and competitive to sound existing programs."

Growth of Health Insurance Coverage . . .

More Than 70 Per Cent of the People in the Nation Are Now Protected By Some Form of Voluntary Health Coverage, Recent Survey Indicates

MORE than $3-billion—a rate of nearly $10-million per day—of the nation's health care bill will be paid in 1957 through voluntary health insurance programs, according to the Health Insurance Council.

This estimate was made by the Council recently based on the results of its annual survey of health insurance coverage in the United States for 1956. Benefit payments to help cover the cost of hospital, surgical, and medical care last year amounted to $2.9-billion, an all-time high.

The Council, in a projection of its 1956 figures on health insurance coverage in the United States, estimates that as of May 1, 1957, some 118-million persons were protected against the cost of hospital expenses through voluntary health insurance programs, 103-million were covered for surgical expenses, 67-million had policies covering regular medical expenses, and 10-million were insured against major medical expenses. These figures, added the Council, mean that over 70 per cent of the total U. S. civilian population today is protected by some form of voluntary health coverage.

The survey, which is made annually by the Health Insurance Council, covering the period from January 1 through December 31, 1956, is based upon reports of health insurance programs conducted by insurance companies, Blue Cross-Blue Shield and other health care plans.

LOSS OF INCOME POLICIES

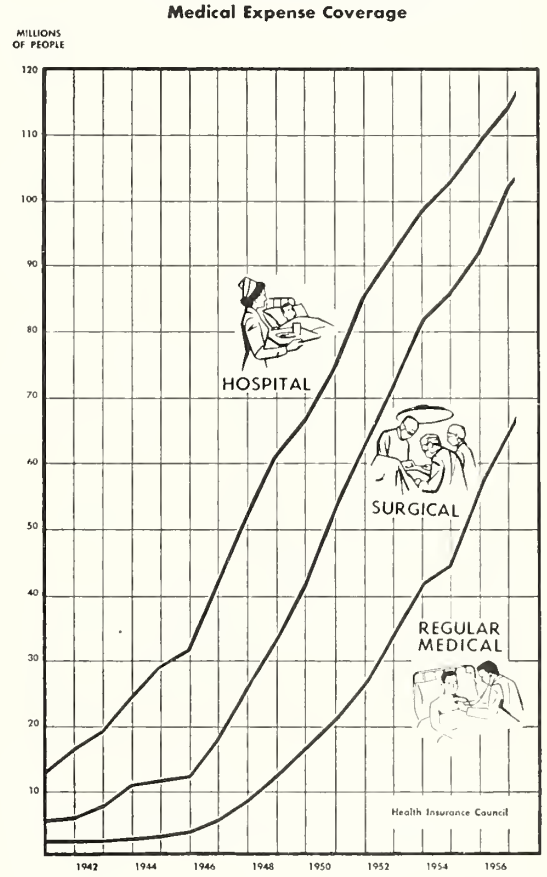
The Council reported that insurance companies in 1956 paid a total of $695-million in benefits to people through loss of income insurance policies, which help replace income lost because of accident or sickness. This figure, added to the $2.9-billion paid in other health benefits, would bring the total benefit payments for the year 1956 to $3.6-billion paid under health insurance programs.

Advances in all types of health insurance coverage were revealed in the Council report. During the year, the number of people covered by hospital care insurance rose by 8-million over the year before, the number of people covered by surgical expense insurance increased 9-million, and persons covered for regular medical expenses rose 9-million.

"The growth in both the number of people covered under plans designed to help pay hospital and doctor bills, and the payments received under these voluntary plans," said the Council, "demonstrates the continued desire of the American people to insure themselves against costs incurred through accident and sickness."

Hospital care insurance, to help pay for services in the hospital, remained the most popular form of health insurance in terms of number of people covered, with 66,259,000 persons holding policies from insurance companies; 53,162,000 enrolled by Blue Cross-Blue Shield; and 4,654,000 protected through miscellaneous plans. Making allowance for people covered by more than one type of insuring organization, the Council reported that over 115.9-million persons were protected by hospital expense insurance.

Growth of Hospital, Surgical, and Regular Medical Expense Coverage



BLUE SHIELD HIGH

Surgical expense insurance, which helps meet the cost of operations, was provided by insurance companies to 62,996,000 persons; 42,570,000 by Blue Cross-Blue Shield; and 4,909,000 by the other health care plans. Allowing for those with dup-

licate health insurance coverage, the survey found 101.3-million persons protected against surgical costs.

Regular medical expense insurance, providing for doctor visits for non-surgical care, accounted for 33,907,000 persons through Blue Cross-Blue Shield; while 29,756,000 were covered by insurance company programs; with 5,276,000 persons insured under the miscellaneous plans. The unduplicated total number of persons having regular medical expense protection was 64.9-million.

Major medical expense insurance, which helps to absorb the cost of serious, or catastrophic illness, continued its dramatic upward trend at year's end, the survey further disclosed. Coverage through insurance companies under all forms of major medical programs rose to 8,876,000 persons. Of these, 8,294,000 had protection through group policies, with the remaining 582,000 insured through individual and family major medical expense policies.

In 1956, the Council report continued, 31,688,000 persons were covered by insurance company loss of income policies. The number of people who work where there is a formal sick leave payment arrangement would bring the total figure to 40,988,000 persons who are protected against loss of income.

The report, as presented by the Health Insurance Council, which is a federation of leading insurance associations representing over 90 per cent of the health insurance in force through insurance companies, is the 11th annual review of the extent of voluntary health insurance coverage in the United States.

AMA Revamps Today's Health Publication Setup

At its recent meeting in Chicago, the AMA Board of Trustees authorized several important changes in connection with the publication of *Today's Health*, which has a monthly circulation of 400,000.

After hearing and discussing a report from its special committee, which was appointed to study all aspects of the magazine, the Board voted to:

Continue publication of the AMA health magazine; make William Hetherington managing publisher with added duties; make the editor of the magazine responsible to the managing publisher for editorial content; set up an Advisory Editorial Board; set up a *Today's Health* advertising department with advertising representatives responsible to the managing publisher; appoint an advertising committee to review advertising copy.

Under the new setup, Mr. Hetherington, who has been with the AMA since July, 1948, will be responsible to the general manager for the management of *Today's Health* and for carrying out AMA policies relating to all activities of the magazine.

You and Your AMA . . .

THE birthplace of American independence—Philadelphia—will be the scene of the American Medical Association's 11th Clinical Meeting December 3-6. Center of activities will be Convention Hall where scientific exhibits, color television, motion pictures, technical exhibits and scientific lectures will be presented "under one roof." Headquarters for the House of Delegates will be the Bellevue-Stratford Hotel.

Highlights of the three-and-a-half day convention geared especially for the nation's family doctors include:

(1) Special trans-atlantic conference between distinguished physicians in London and Philadelphia on "Advances in Chemotherapy of Cancer" via two-way telephone at 3 p. m. EST Wednesday;

(2) Complete color television schedule of surgical demonstrations emanating from Lankenau Hospital;

(3) Motion picture program daily plus a special session Tuesday evening;

(4) Exhibits featuring a well-rounded program and special displays on the history of medicine in the Philadelphia area, fractures and manikin demonstrations on problems of delivery;

(5) Panel discussions on cardiovascular disease, cancer, emotional problems of menopause, hypertension, diabetes, arthritis, traumatic injuries;

(6) The General Practitioner of the Year Award to be presented by AMA to an outstanding family doctor.

MEDICOLEGAL FORMS

To guide physicians and hospitals in the selection of appropriate medicolegal forms, the AMA's law department has compiled a series of six brief articles for *The Journal of the AMA*. In addition, the law department will publish a booklet encompassing the material plus case citations and legal analyses.

Chief purpose of this material will be to provide up-to-date information and miscellaneous mediocolegal forms which physicians and their attorneys may adapt for their own needs. Subjects to be covered: (1) consent to operations and other medical procedures; (2) patient's right to privacy; (3) confidential communications and records; (4) artificial insemination; (5) the physician-patient relationship; (6) autopsy.

POSTGRADUATE COURSES FOR PHYSICIANS LISTED

One of the services of the AMA, through its Council on Medical Education and Hospitals, is the listing of postgraduate courses for physicians. In the August 17 issue of the *Journal of the AMA* beginning on page 1773 is a list of courses from September 1, 1957, to August 31, 1958, listed by type of practice.

Survey of Blood Banks . . .

What Areas Do They Cover? Are They Capable of Expansion? How Do They Operate? Answers To Such Questions Are Sought by Joint Council

MORE than 5,200 hospitals, blood banks and other blood transfusion services were scheduled to receive a questionnaire from the Joint Blood Council, representing a major effort to provide a guide to blood banking and related activities in the United States and Territories.

The Joint Blood Council, Inc., with offices at 1832 M Street, Northwest, Washington, D. C., is sponsored by the American Medical Association, the American Association of Blood Banks, the American Hospital Association, the American National Red Cross and the American Society of Clinical Pathologists.

The questionnaire represents a second phase of the Joint Blood Council's efforts to bring the blood transfusion picture into focus. The first phase was a post card survey of blood usage during 1956. That survey produced some unpredicted information on the sources of blood in the United States.

The Council itself grew out of the need for closer cooperation among facilities which handle blood and between the independent blood banks and the regional and national blood banking systems. Its survey of blood transfusion services is another step in that direction, according to Dr. Frank E. Wilson, executive vice-president and secretary.

The Council's preliminary research confirmed the conviction that blood transfusion services are operating under handicaps. The current questionnaire is expected to help clarify various problems and lead to a remedy of most of the serious obstacles. Dr. Wilson stated that the Council shares with the medical profession the recognition of such deficiencies as no satisfactory system for exchanging blood or blood credits on a nationwide scale.

Terminology and nomenclature is another field in which clarification is needed, Dr. Wilson pointed out. In some instances a "unit" is 480 cc. and in others 250 cc., and there are further variations. The term "blood bank" has a variety of meanings.

The AMA and other sponsors of the Blood Council have endorsed the survey as a much needed study. Such governmental agencies as the Veterans Administration, the Office of Defense Mobilization are also interested in the outcome, Dr. Wilson stated.

Information sought in regard to blood transfusion services includes answers to the following questions:

Are they capable of rapid expansion in time of emergency?
Where are they located?
How are they organized and operated?
What areas do they serve?
What is their annual volume of business?
How do they relate to allied services, such as tissue banks?

What To Write For

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

HR 53. Consolidation of all Federal laws pertaining to medical care, hospitalization, pensions and other benefits for veterans, compensable diseases, presumption of service-connection, etc. Write House Committee on Veterans Affairs, House Office Building, Washington 25, D. C.

* * *

Cerebral Vascular Disease and Strokes. Designed for lay public, this new illustrated publication deals with diseases of blood vessels of the brain, third ranking cause of death in U. S., and steps in treatment and rehabilitation. Write Heart Information Center, National Heart Institute, Bethesda 14, Md.

* * *

Occupations of Paraplegic Veterans of World War II and Korea. Nearly 500 cases of such veterans who have successfully overcome severe physical handicaps. (35 cents) Write Government Printing Office, Washington 25, D. C.

* * *

Your Child. List of 24 publications covering child care from birth to the middle teens. Write Superintendent of Documents, Government Printing Office, Washington 25, D. C.

* * *

Whitehall 4-1500. Pamphlet describes how AMA film helps medical societies explain to the public doctors' services—not just as individuals but as members of medical organizations. Film is 30 minutes, sound, color. Write Film Library, AMA, 535 N. Dearborn St., Chicago 10, Ill.

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

Joint Commission on Mental Illness and Health has 12 separate studies under way, and plans 13 additional investigations if funds become available. Largest study group is on patterns of patient care, and the group is surveying activities of voluntary organizations of former mental patients.

* * *

Regulations for loans to hospitals for construction of housing for interns and student nurses have been announced by the Community Facilities Administration. Total available is $25 million, with a $2.5 million limit within a state. Loan period is for 40-year maximum, and interest rate is 3 per cent.

* * *

HEW Secretary Folsom has named a special committee of medical and industrial leaders to study the "status and future needs" of medical research and education. Committee is expected to come up with (1) impact of expanding research programs on medical education; (2) availability of scientists, technicians and facilities; (3) relative emphasis given to research in the various disease fields; (4) relative emphasis given to fundamental studies in the basic sciences generally; (5) relationship between federal and private research programs, and (6) standards for approval of research projects. Committee members include Dr. Irvine H. Page, director of research, Cleveland Clinic Foundation.

* * *

Expected to attract support in the 1958 Congressional session is the AFL-CIO bill (HR 9467) to amend Social Security Act to increase benefits and provide hospitalization, nursing home and surgical care privileges for OASI recipients. Provisions are most generous of any of the several similar bills.

* * *

More than 2,000,000 veterans are receiving increased compensation pay for service-connected disabilities. A large majority of the recipients receive 10 per cent more while veterans totally disabled receive a 24.3 per cent increase.

* * *

Oak Ridge National Laboratory has made 100,000 shipments of radioisotopes since program of peacetime uses of atomic energy started in 1946, Atomic Energy Commission reports. AEC estimates more than 4,000 organizations are licensed to use such isotopes, and many others are receiving small quantities of radioactive material under a general license.

Annual fiscal report of United Mine Workers Welfare and Retirement fund for year ending July 1 shows fund paid $59,584,494 to 93,679 persons for hospital and medical care benefits, up 25 per cent over previous year. Expenditures were for 1,631,144 hospital days, 1,556,111 visits by physicians and 885,944 office and out-patient clinic consultations through additional services of specialists.

* * *

Clinical knowledge of the extent to which antibiotics may be losing their effectiveness against certain infections is expected to be gained from a study launched by the Veterans Administration. Six VA hospitals and a Canadian veterans hospital are cooperating in the project.

* * *

Medicare hospital claims from launching of program in December, 1956, to July 1 of this year were 103,595 dependents, at a cost of $10,732,272. Physicians' claims showed 127,902 dependents treated at a cost of $8,805,128 over the same period; 80 per cent of Medicare patients are female.

* * *

Among new members of Veterans Administration Special Medical Advisory Group installed in Washington September 9 was Dr. Robert H. Ebert, Cleveland. Group meets quarterly to advise chief medical director of VA on professional problems.

* * *

Budget Bureau has reversed its plan to "freeze" more than $17-million appropriated for medical research. All institutions approved for a research project by the National Institutes of Health advisory committee in June have been notified that funds will be made available.

* * *

Fourteen pages of antivivisectionists propaganda (costing $77 per page) were inserted in the Congressional Record for August 21 by Senator Morse (D-Ore.) Morse said he was not an a. v. but also said he was concerned over the material.

* * *

The U. S. Atomic Energy Commission has announced publication of a 579 page handbook providing the latest knowledge of weapons effects. The handbook entitled "The Effects of Nuclear Weapons" was prepared by the Armed Forces Special Weapons Project of the Department of Defense. This book is on sale for $2.00 per copy by the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.

In Memoriam . . .

Robert L. Alter, M. D., Toledo; Duke University School of Medicine, 1937; aged 44; died August 7; member of the Ohio State Medical Association, the American Medical Association, the International College of Surgeons; Fellow of the American College of Surgeons; diplomate of the American Board of Obstetrics and Gynecology. Before he moved to Toledo, Dr. Alter's experiences included practice in Durham, N. C., an appointment on the faculty of Duke University School of Medicine, a lecture tour in Germany under auspices of the International Refugee Organization and an appointment on the faculty of the American University, Beirut, Lebanon. Survivors include his widow, a daughter, three sisters and four brothers, three of whom are physicians —Dr. Francis W. Alter, San Mateo, Calif.; Dr. Albert J. and Dr. George F. Alter, both of Toledo.

Charles A. Bates, M. D., Dalton; Ohio State University College of Medicine, 1947; aged 38; died August 30; member of the Ohio State Medical Association and the American Medical Association. Dr. Bates began his professional career as a private practitioner in Dalton but gave it up in 1953 for health reasons and accepted an appointment on the staff of the Massillon State Hospital. He transferred to Apple Creek State Hospital as staff psychiatrist in 1955. Dr. Bates was instrumental in preparing the course for the clergy which was given at the hospital last fall. He was a member of the board of directors of the Tri-County Mental Guidance Center, a member of the Stark County Mental Health Association, the Dalton Community Club, the Ohio Civil Service Association and the Methodist Church. Surviving are his widow, two daughters, his step-mother and a brother.

Marion Arthur Blankenhorn, M. D., Cincinnati; Western Reserve University School of Medicine, 1914; aged 71; died September 3; member of the Ohio State Medical Association, the American Medical Association, the Association of American Physicians, the American Society of Experimental Pathology, the American Society for Clinical Investigation and Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. A distinguished physician and medical educator, Dr. Blankenhorn was for many years professor of medicine at the University of Cincinnati and director of the Department of Internal Medicine; he held the distinguished chair, the Gordon and Helen Hughes Taylor professor of medicine. Dr. Blankenhorn's interest in teaching began at Western Reserve where he held appointments before World War I. During that war he served as captain with the first medical unit of the Army to depart for France. After 22 months overseas he returned to the teaching staff of Western Reserve. He went to Cincinnati in 1935. In the 1930's he directed medical research in the field of nutrition, a project which was instrumental in developing treatment for pellegra. During World War II he conducted studies in the effects of high altitudes for the Office of Scientific Research and Development. He also was medical consultant for the Far East Command in 1948 and for the European Theater of Operations in 1951. He directed studies in the 1930's of hospital standards in medicine for the American College of Physicians; was former governor for Ohio of the ACP and its vice-president in 1956. The honorary degree of Doctor of Laws was conferred upon him by the University of Cincinnati at the 1957 commencement. Dr. Blankenhorn belonged to the Literary Club and the Presbyterian Church. Survivors include his widow; two daughters, one of whom is Dr. Jane Blankenhorn Schieve of Columbus; a son, Dr. David Blankenhorn, Pasadena, Calif., and a sister.

Stephen W. Boesel, M. D., Niles; Western Reserve University School of Medicine, 1915; aged 67; died September 4; member of the Ohio State Medical Association and the American Medical Association. Dr. Boesel had been a practicing physician in Niles since 1916. For the past 16 years he also was city health commissioner. Affiliations included memberships in the Episcopal Church and the Youngstown Club. Surviving are his widow, four daughters, three sons, two brothers and four sisters.

Henry W. Dierksheide, M. D., Pemberville; Eclectic Medical College, Cincinnati, 1918; aged 63; died August 26; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Dierksheide served all of his professional career in Pemberville and vicinity. In addition to his professional activities, he was president of the local Citizens Savings Bank and an officer in the Lutheran Church. Survivors include his widow, two sons, a daughter, three sisters and two brothers. One son, Eugene, graduated from the Ohio State University College of Medicine in June and is now in internship training.

Joseph H. Krape, M. D., Kent; Jefferson Medical College, 1894; aged 89; died September 3; former member of the Ohio State Medical Association and the American Medical Association. Dr. Krape devoted a total of 63 years of medical practice to the people of the Kent vicinity, being in semi-retirement only in the past few years. His service was recognized in 1951 when the Kent Chamber of Commerce awarded him the public service medal. He also had been honored by the Portage County Medical Society by being presented the OSMA 50-Year Award. He was a

member of the Methodist Church, the Masonic Lodge and Phi Gamma Delta. Two daughters and a sister survive.

Alan D. Knisely, M. D., Lima; Kentucky University Medical Department, 1906; aged 76; died September 1; member of the Ohio State Medical Association, the American Medical Association, the American Academy of Ophthalmology and the American Laryngology, Rhinology and Otology Society; diplomate of the American Board of Otolaryngology. Dr. Knisely began practice in Lima in 1906 upon completion of his medical training. He had been honored with the 50-Year Award of the OSMA. Affiliations included memberships in the National Triological Society, the Shawnee Country Club, the Elks Lodge, the Masonic Lodge, Sigma Chi and Phi Chi, the Episcopal Church, the Rotary Club and the American Legion. He served during both World Wars, in the first as captain and during the second as lieutenant colonel in the Medical Corps. Surviving are a son, a daughter, and a brother.

Charles D. Leach, M. D., Granville; College of Physicians and Surgeons, Boston, 1910; aged 74; died August 31; member of the Ohio State Medical Association and the American Medical Association. Upon completion of his internship, Dr. Leach served 15 years as a member of the staff of the Huchow Union Hospital in Eastern China. Returning to the United States, he opened an office in Croton in 1928 and a few years later moved to Granville where he practiced for 24 years. Dr. Leach also had an office in Newark. He was a member of the Baptist Church, and was on the board of the Ohio Baptist Education Society. Surviving are his widow, three sons, one daughter and two sisters.

Eugene Mankovich, M. D., Lakewood; Royal Hungarian University Faculty of Medicine, 1923; aged 64; died August 24; member of the Ohio State Medical Association and the American Medical Association. A native of Czechoslovakia, Dr. Mankovich came to this country in 1927 and received his citizenship in Cleveland in 1929. His practice included appointments on several Cleveland hospital staffs and an appointment as Cuyahoga County jail physician. He was a member of the Cleveland Chamber of Commerce and the Hungarian Professional Men's Society. His widow and a sister survive.

Edward E. Mattox, M. D., Pittsburgh, Pa.; Maryland Medical College, 1912; aged 78; died August 15. A practicing physician in Pittsburgh for many years, Dr. Mattox was known in the East Liverpool area where he formerly resided.

George E. McCullough, M. D., Troy; Medical College of Ohio, Cincinnati, 1899; aged 84; died August 13; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. A native of Troy, Dr. McCullough practiced there

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for 52 years before his retirement. In early years, Dr. McCullough operated a private hospital in Troy; was later chief of surgery service at Stouder Hospital and was on the board of Dettmer Hospital. He served more than 25 years on the local School Board, was a member of the Presbyterian Church and the Rotary Club. Surviving are his widow, two daughters and a brother.

Earl H. Morris, M. D., Dayton; Medical College of Ohio, Cincinnati, 1903; aged 84; died August 5; member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award. Dr. Morris served all of his career in the Dayton vicinity, having started in practice at nearby Zimmerman. He practiced for 52 years before his retirement in 1955 and for most of that time was physician for the Railway Express Company. Surviving are his widow, two daughters, two sons and a brother.

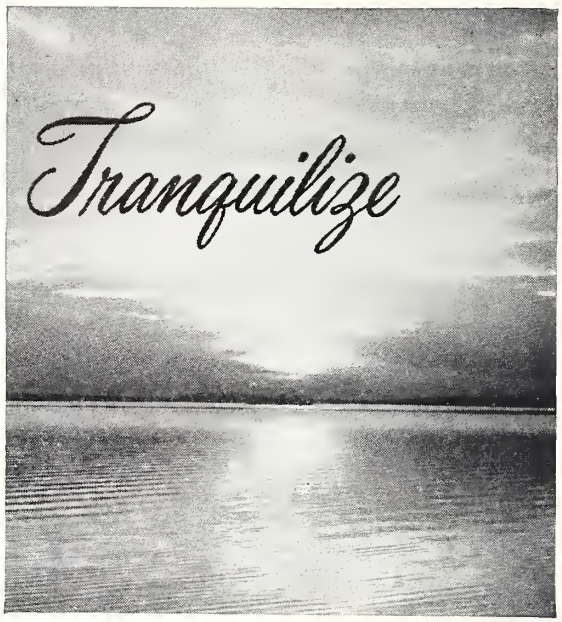
Malcolm R. Patterson, M. D., Cleveland; Maharry Medical College, Nashville, 1951; aged 45; died August 19; member of the Ohio State Medical Association and the American Medical Association. A native of Cleveland, Dr. Patterson returned there to practice following his internship. A veteran of World War II, he was a member of the Cory Methodist Church and Alpha Phi Alpha. Surviving are his widow, his parents, three sisters and four brothers.

John E. Price, M. D., Fort Thomas, Ky.; University of Cincinnati College of Medicine, 1931; aged 56; died August 3. Dr. Price was senior ward physician at the Veterans Hospital, Ft. Thomas. He was a veteran of World War II. His parents survive.

Ernest V. Reutinger, M. D., Columbus; Ohio Medical University, Columbus, 1906; aged 78; died August 14; former member of the Ohio State Medical Association. Dr. Reutinger practiced for more than 50 years in Columbus and was given the 50-Year Award of the Ohio State Medical Association. He was a member of the Catholic Church, the Holy Name Society and St. Vincent DePaul Society. Survivors include his widow, a son, two daughters and a sister.

Roy R. Reynolds, M. D., Massillon; University of Maryland School of Medicine, 1919; aged 64; died August 11; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Massillon for 33 years, Dr. Reynolds moved there in 1914. He took specialty work at Johns Hopkins University and on three different occasions went to Europe for additional study in EENT work. A veteran of World War I, he was a member of the Rotary Club and several Masonic orders. Survivors include his widow, two daughters, a sister and two brothers.

Paul W. Smith, M. D., Lorain; Emory University School of Medicine, 1935; aged 49; died



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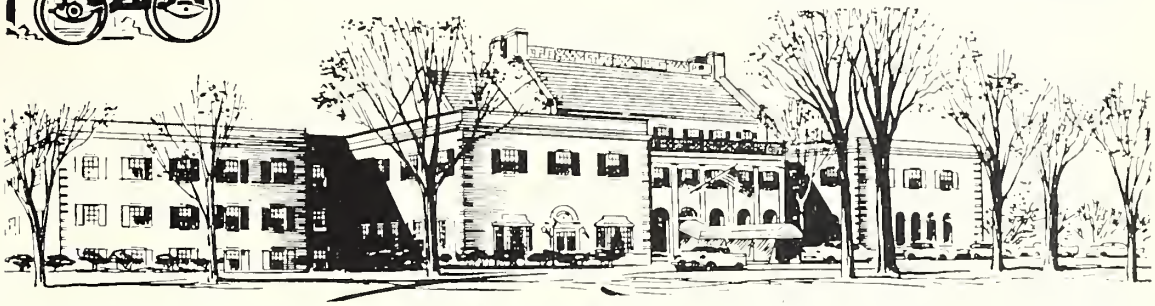
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August 29; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Smith practiced medicine in Lorain for 21 years, interrupting his practice for several years of service in the Air Force. He was a member of the American Legion, the Lorain Yacht Club, Oak Hills Country Club, the Masonic Lodge and the Christian Temple Church. Survivors include his widow, two sons, two daughters, a sister and a brother.

Elizabeth Dial Spreng, M. D., Cleveland; Western Reserve University School of Medicine, 1923; aged 60; died September 2; former member of the Ohio State Medical Association, the American Medical Association, and the Cleveland Women's Medical Society. A practicing physician in Cleveland for 35 years, Dr. Spreng was one of a family of physicians. Her grandfather and father before her were physicians. She and her husband, Dr. Dwight S. Spreng, were classmates in medical school. Besides her husband she is survived by a son, Dr. Dwight S. Spreng, Jr.; daughters, Dr. Katherine Spreng and Mrs. Barbara Buatois; brothers, Drs. Robert, Ralph and Donald Dial.

Lester L. Taylor, M. D., Yellow Springs; Starling Medical College, Columbus, 1897; aged 93; died August 22; former member of the Ohio State Medical Association. A practicing physician over a period of more than a half-century, Dr. Taylor began his professional career in Fairfield, now a part of Fairborn. He moved to Yellow Springs in 1904 and practiced there until his retirement in 1949. He was honored on several occasions by local citizens for his service to the community. He was an elder in the Presbyterian Church. Surviving are a son, four daughters and a brother.

David E. Weaver, M. D., Cleves; Medical College of Ohio, Cincinnati, 1904; aged 77; died August 24; former member of the Ohio State Medical Association. Dr. Weaver had been a practicing physician in the Greater Cincinnati area for more than a half-century. A native of Cheviot, he was a member of the Masonic Lodge and the Junior Order of Mechanics. Surviving are his widow, a daughter and a brother.

American College of Gastroenterology To Convene in Boston, Oct. 21-23

The 22nd annual convention of the American College of Gastroenterology will be held at the Somerset in Boston, Mass., October 21-23. Sessions are open to all physicians without charge.

On October 24, 25 and 26, immediately following the convention, Dr. Owen H. Wangensteen, of Minneapolis, Minn., and Dr. I. Snapper, of Brooklyn, N. Y., will again be moderators of the annual course in postgraduate gastroenterology.

Copies of the program and further information may be had by writing the college at 33 West 60th St., New York 23, N. Y.

Akron Group Sponsors Program on Inhalant and Food Allergy

Dr. Herbert J. Rinkel, of Kansas City, Mo., will conduct a three-day course on Inhalant and Food Allergy in Akron, December 6-8. Other lecturers will be Dr. D. E. Cowen, of Denver, Colorado, and Dr. Dor Brown, Fredricksburg, Texas. This course is being sponsored by the Akron Academy of Ophthalmology and Otolaryngology. For further information and reservations contact Dr. Richard H. Stahl, 2674 North Haven Blvd., Cuyahoga Falls, Ohio.

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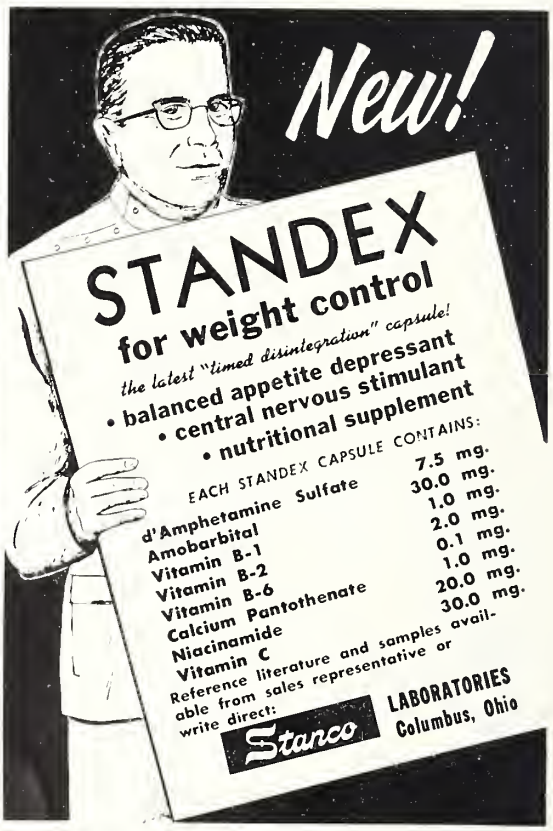
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Activities of County Societies . . .

First District

(COUNCILOR: FRANK H. MAYFIELD, M. D., CINCINNATI)

CLERMONT

The Clermont County Medical Society met on September 18, with Dr. Walter Culley, Bethel, as host. Speaker was Dr. Ralph Eddy, Cincinnati, who discussed, "Abdominal Uterine Bleeding, Diagnosis and Treatment."

HAMILTON

The annual meeting of the Academy of Medicine of Cincinnati was held on September 17 at which time reports of standing committees were heard, the presidents' addresses were delivered and officers installed.

Officers and Council for 1957-1958 are: Dr. George X. Schwemlein, president; Dr. J. Robert Hudson, president-elect; Dr. Howard D. Fabing, past-president; Dr. Norbert H. Cavanaugh, secretary; Dr. Harvey G. McCandless, treasurer; trustees—Drs. Richard D. Bryant, Earl C. Van Horn and Joseph N. Ganim; councilmen-at-large—Drs. Stanley D. Simon, Clyde S. Roof and Morton Hamburger. Dr. Frank H. Mayfield is councilor of the First District. Mr. Edward F. Willenborg is executive secretary of the Academy.

Featured in the scientific program was a talk on "The Asian Influenza" by Dr. Alexander D. Langmuir, associate professor of bacteriology, Emory University School of Medicine, and chief of the Epidemiology Branch, Communicable Disease Center, U. S. Public Health Service, Atlanta, Georgia.

The Cincinnati Surgical Society held a meeting on September 11 in the Queen City Club. Dr. Frank Glenn, professor of surgery, Cornell University Medical College, delivered the George J. Heuer Memorial Lecture on the subject, "Diseases of the Biliary Tree."

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

DARKE

Members of the Darke County Medical Society, the Woman's Auxiliary and guests met for dinner and a program at the White Shrine Temple, Greenville, on September 17. Helen Deeter Warner presented a "Travelogue of the South Pacific."

MIAMI

Dr. H. William Clatworthy, Jr., chief of pediatric surgery, Children's Hospital, Columbus, spoke on the subject "Lumps in Kids," at the September 6 meeting of the Miami County Medical So-

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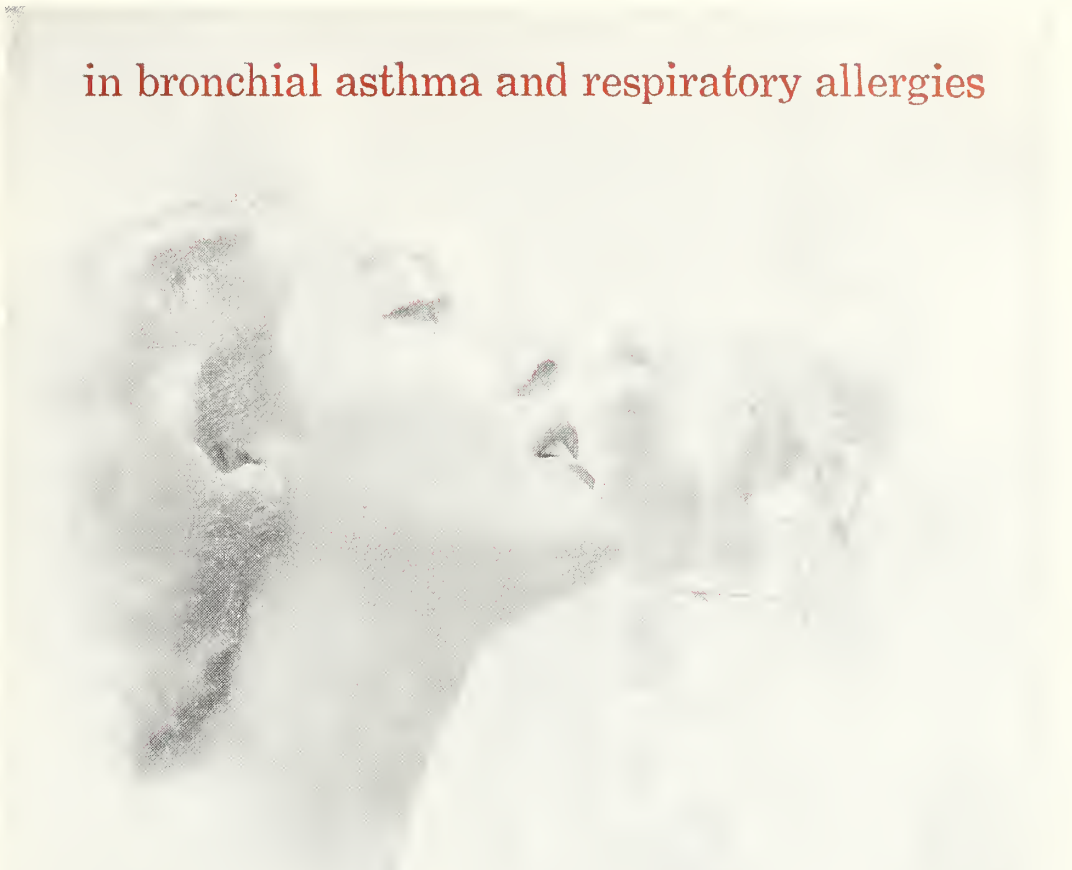
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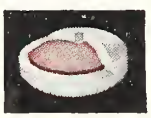
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ciety. The meeting was held at the Dettmer Hospital, Troy, followed by dinner.

MONTGOMERY

The Dayton Obstetrical & Gynecological Society met on September 18 in the Van Cleve Hotel. Following a social hour and dinner, the speaker of the evening, Dr. Vinton E. Siler, University of Cincinnati, spoke on "Some Surgical Complications of Obstetrics and Gynecology." Moderator for the program was Dr. J. M. Shaffer.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

FULTON

The Fulton County Medical Society met at Archbold, September 10, for its regular quarterly meeting. New members were received. The Society is in process of changing its constitution so that it will be a copy of the model constitution suggested by the State Association. The next reading of the proposed new constitution will be at the December meeting.

Members discussed a local contract with County Aid for the Aged personnel. Copies of the contract will be sent to Dr. Paul F. Orr, Fourth District Councilor and to the district representative with a statement that members are dissatisfied with the present rate of payment and with the suggestion that patients be billed at the listed schedule and the money be put in the educational trust fund.

There was discussion about ways to obtain money for a flame photometer. There also was discussion about the Asiatic flu vaccine.

Dr. Orr, discussing action of the OSMA House of Delegates, said that the House favored in principle a federation at the local level embracing all voluntary health agencies and the raising of funds for such federation through a single drive. Notice of this action will be presented to various county newspapers for publication.—R. A. Ebersole, Secretary.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

The Stark County Medical Society is preparing to play host to the Sixth Councilor District Postgraduate Day group on October 23. Program for this event will be at the Onesto Hotel, Canton.

SUMMIT

The Summit County Medical Society met on September 3 for dinner in the Akron City Club, followed by a program at the Akron General Hospital Auditorium. Two speakers were featured on the program. Dr. Edgar A. Kahn, professor of surgery, University of Michigan, spoke on the subject, "Head Injuries." Robert H. Fredericks, supervisor of the Advanced Vehicles Department, Ford Motor Company, discussed the subject, "Re-

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SURGERY—Surgical Technic, two weeks, Oct. 28, Nov. 11. Surgery of Colon & Rectum, one week, Nov. 18. Treatment of Varicose Veins, Nov. 18, Dec. 16. Gallbladder Surgery, three days, Nov. 4. Surgery of Hernia, three days, Nov. 7. General Surgery, one week, Oct. 28. Fractures & Traumatic Surgery, two weeks, Oct. 21.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Oct. 21. Vaginal Approach to Pelvic Surgery, one week, Oct. 14. General & Surgical Obstetrics, two weeks, Nov. 4.

MEDICINE—Gastroscopy & Gastroenterology, two weeks, Nov. 4. Dermatology, two weeks, Oct. 14.

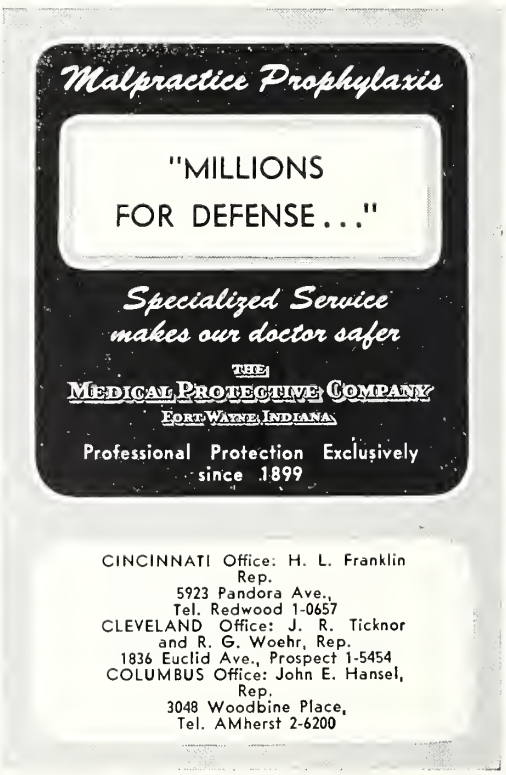
PEDIATRICS—Pediatric Cardiology, two weeks, Dec. 2.

RADIOLOGY—Diagnostic X-Ray, two weeks, Dec. 2.

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Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

COSHOCTON

Considerable planning on the part of officers of the Coshocton County Medical Society has gone into a program in connection with opening of the Coshocton County Memorial Hospital scheduled in early October. Members of Medical Societies in surrounding counties have been invited to a program and open house.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

LAWRENCE

The bulletin of the Lawrence County Medical Society contained an appeal for members to support the United Fund of Ironton and Lawrence County. Dr. George N. Spears, secretary of the Society, is also president of the United Fund for this year. Supplements to the bulletin were copies of the AMA Washington Office bulletin on the influenza situation and a copy of Dr. Louis J. Regan's "List of 'Commandments' in Malpractice Prevention."

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

The Columbus Academy of Medicine and the Metropolitan Health Council cooperated with Children's Hospital, of Columbus, to expand the Poison Control Center at the hopital and make it one of the finest and most effective centers in its field. Commenting editorially on this service, the *Ohio State Journal* said: "Children's Hospital recently has added one of the finest stand-by services that can be provided in this day of chemical wonders. . . . Doctors and hospital emergency staffs can quickly obtain information with respect to the poison and administer an effective antidote. Learning the contents of a poison substance takes only the time required to make a telephone call."

Cardiac Emergencies During Anesthesia; Lecture by Dr. Wright Featured By Heart Group in Columbus

The Central Ohio Heart Association, with offices at 50 E. Broad Street in Columbus, has announced two scientific programs to be given at Ohio State University. The first is on "Cardiac Emergencies Arising During Anesthesia," scheduled November 1 and 2. The second, scheduled November 14, will be on the subject of anticoagulants in cardiovascular disease and occlusive arterial disease.

CARDIAC EMERGENCIES DURING ANESTHESIA

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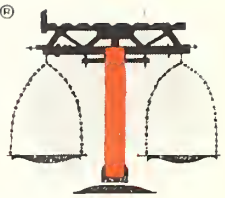
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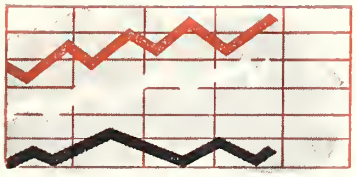
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sponsored by the Central Ohio Heart Association, the series to be launched with a course November 1 and 2 at Ohio State University. Director of the classes will be Dr. Jay Jacoby, chairman of the Anesthesia Department, Ohio State University. Other Ohio State University faculty members on the teaching staff will be Dr. John R. Jones of the Anesthesia Department; Dr. Joseph E. Ryan, assistant professor of medicine; and Dr. Joseph Tomashefski, assistant professor of medicine and physiology and chief of research at Ohio Tuberculosis Hospital.

Courses will emphasize cardiac resuscitation, preparation of the poor-risk patient for surgery, safeguards during anesthesia and care of the cardiac arrhythmia during surgery. Included will be personal instruction in resuscitating a dog and active discussion periods.

The first course will be held from 8 to 10:30 p. m. on November 1, and from 9 a. m. to noon, Saturday, November 2, just before the Ohio State University game with Northwestern University. The class will meet in Room M-100, Starling-Loving Hospital, Health Center, Ohio State University. Limit is 25 persons and registration $5.

LECTURE BY DR. WRIGHT

Ohio physicians are invited to attend a lecture by Dr. Irving S. Wright, professor of clinical medicine at Cornell University's College of Medicine, and authority in the field of anticoagulants in cardiovascular disease. The meeting, to be held November 14 in Room M-100, Starling-Loving Hospital of Ohio State University, is being sponsored by the Scientific Council of the Central Ohio Heart Association.

The November meeting will open at 10 a. m. with Dr. Wright participating with a group of local physicians in a panel discussion of "The Evaluation of the Use of Anticoagulants in Cardiovascular Disease." Panel moderator will be Dr. J. S. Silberstein, while panel members will include Drs. Wright, Philip Knies, Anthony Anton, Robert Wall and Richard Patton. Dr. Wright will serve as guest discussant in Medical Grand Rounds conducted by Dr. Bruce Wiseman.

After a luncheon at the Jai Lai Restaurant, the meeting will resume with Dr. Wright's discussion of "A Critical Analysis and Present Therapy of Occlusive Arterial Disease."

The event is first in a series of three featuring outstanding visiting speakers at Scientific Council meetings in 1957-58.

North Wing Being Added to University Hospital in Columbus

Scheduled to be completed by early 1959 is the new 11-story north wing to University Hospital on the Ohio State University campus in Columbus. Contracts for the job total more than $3-million.

The addition will include teaching class rooms, research laboratories, radiation therapy facilities, expansion of the maternity section.

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Columbus Pharmacal Company 1138
Cook County Graduate School of Medicine 1208
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Dearborn Inn 1203
Desitin Chemical Company 1225
Flint, Eaton & Company 1211
Geigy Pharmaceuticals, Inc. 1221
General Electric Company, X-Ray Dept. 1221
Harding Sanitarium 1120
Lakeside Laboratories, Inc. 1101
Lederle Laboratories 1102, 1119, 1133, 1172-1173, 1197, 1201, 1203, 1215, 1223
Lewal Pharmaceutical Company 1198
Liebel-Flarsheim Co. 1129
Lilly, Eli, and Company 1140
Lloyd Brothers, Inc. 1219
Mallard, Inc. 1202
McMillen Sanitarium 1120
Medical Protective Company 1208
Merck Sharp & Dohme 1130, 1137, 1207, 1217
New York Polyclinic Medical School 1191
Parke, Davis & Company ..... 1117, 1228 and Inside Back Cover
Patch, E. L., Company, The 1220
Pfizer, Chas. & Co., Inc. 1107
Picker X-Ray Corporation 1112
Quincy X-Ray & Radium Lab 1204
Rich Company, Incorporated 1216
Robins, A. H., Co., Inc. ..... 1114-1115, 1123, 1189, and insert between pages 1164-1165
Roche Laboratories, Division of Hoffmann-LaRoche, Inc. ..... 1227 and insert between pages 1220-1221
Roerig, M. B., & Co. 1113, 1126-1127
Sanborn Company 1134
Sawyer Sanatorium 1128
Schering Corporation 1139
Scroggins, Clayton L., Associates (Medical-Dental Management) 1138
Searle, G. D. & Company 1187, 1191
Smith, Kline & French Laboratories ..... 1214 and Back Cover
Squibb, E. R., & Sons, Division of Olin-Mathieson Chemical Corporation 1131
Stanco Laboratories 1204
Stoneman Press 1119
Tutag, S. J., & Company 1189
Upjohn Company 1205
Wallace Laboratories ..... Insert between Pages 1128-1129
Wendt-Bristol Company 1200
Windsor Hospital, Inc. 1213
Winthrop Laboratories 1124-1125, 1169, 1209

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(Continued on next page)

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BROWN—John R. Donohoo, President, Ceorgetown; Leslie Hampton, Jr., Secretary, Sardinia. 1st Sunday, monthly.

BUTLER—Ralph H. Leyrer, President, Hamilton; Mr. Charles G. Creig, Executive Secretary, 110 North Third Street, Hamilton. Beginning in February 4th Wednesday of alternate months.

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FIFTH DISTRICT

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SUMMIT—Robert G. McCready, President, Akron; Miss Betty Haydon, Office Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly, September through June.

TRUMBULL—Joseph A. Browning, President, Warren; Robert J. Willoughby, Secretary, Warren. 3rd Wed., monthly.

SEVENTH DISTRICT

BELMONT—A. John Antalis, President, Powhatan Point; Bertha M. Joseph, Secretary, Martins Ferry. 3rd Thursday, except July, August.

CARROLL—P. S. Whiteleather, President, Minerva; Robert H. Hines, Secretary, Minerva.

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HARRISON—Carl J. Nicosia, President, Bowerston; Richard W. Weiser, Secretary, Jewett. Meetings: March, June, September, December.

JEFFERSON—Warren G. Snyder, President, Wintersville; Frances J. Shaffer, Secretary, Toronto. 2nd Tuesday.

MONROE—Byron Gillespie, President, Woodsfield; Albert R. Burkhart, Secretary, Woodsfield.

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Current Concepts in

Feeding Newborns

Successful infant feeding depends on effective planning of the newborn's nutritional regimen. The first feeding, 12 hours after birth, may consist of a prelacteal solution of KARO® Syrup. This should be offered in one or two ounce amounts at two hour intervals for 24 to 48 hours to fulfill the high water requirement during the first week of life. Breast feeding may be initiated on the second day for five minute intervals to obtain colostrum and stimulate breast secretion. However, the prelacteal feeding is continued thereafter and between nursings.

Artificial feeding is offered on the second day if breast feeding is denied. Small infants are fed at three hour intervals and large infants at four hour intervals. The initial formula usually is a low caloric milk mixture to enable gradual adaptation of the feeding to the infant's tolerance. Concentration of the formula is gradually increased at intervals of several days, in the absence of digestive disturbances. The infant should be fed in a semi-reclining position, burped during and after feeding, and kept on his right side or abdomen undisturbed for an hour.

The same problems of infant feeding recur from generation to generation, but solutions may differ with each era. The carbohydrate requirement for all infants is as completely fulfilled by KARO Syrup today as a generation ago. Whatever the type of milk adapted to the individual infant, KARO Syrup may be added confidently because it is a balanced mixture of low molecular weight sugars, readily miscible, well tolerated, palliative, hypoallergenic, resistant to fermentation in the intestine, easily digestible, readily absorbed and non-laxative. It is readily available in all food stores.

Rx FIRST FORMULAS FOR NEWBORNS ADAPTED ACCORDING TO TOLERANCE

FORMULA I .....11 cals./oz.
*Whole Milk ..... 8 oz.
Water .....12 oz.
Karo .....½ oz.
3½ oz. x 6 q 4h.

FORMULA I .....12.5 cals./oz.
**Evap. milk ..... 4 oz.
Water .....14 oz.
Karo .....½ oz.
3½ oz. x 6 q 4h.

FORMULA I .....11 cals./oz.
Dried milk .....4 tbsp.
Water .....20 oz.
Karo .....½ oz.
3½ oz. x 6 q 4h.

FORMULA III .....16 cals./oz.
Whole milk .....10 oz.
Water .....10 oz.
Karo ..... 1 oz.
3½ oz. x 6 q 4h.

FORMULA III .....20 cals./oz.
Evap. milk ..... 6 oz.
Water .....12 oz.
Karo ..... 1 oz.
3 oz. x 6 q 4h.

FORMULA III .....18 cals./oz.
Dried milk .....6 tbsp.
Water .....20 oz.
Karo ..... 1 oz.
3½ oz. x 6 q 4h.

FORMULA II .....13.5 cals./oz.
Whole milk ..... 9 oz.
Water .....11 oz.
Karo .....¾ oz.
3½ oz. x 6 q 4h.

FORMULA II .....16 cals./oz.
Evap. milk ..... 5 oz.
Water .....13 oz.
Karo .....¾ oz.
3 oz. x 6 q 4h.

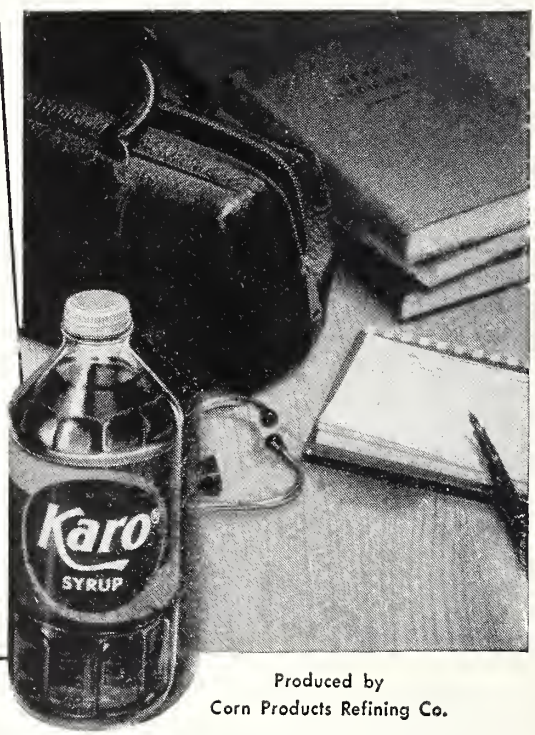
FORMULA II .....14.5 cals./oz.
Dried milk .....5 tbsp.
Water .....20 oz.
Karo .....¾ oz.
3½ oz. x 6 q 4h.

*Whole loctic acid milk formulos may olso be prepored from whole cow's milk.

**Whole lactic acid milk formulos may olso be prepared from evoporoted cow's milk.

Adapted from Nelson's Pediotrics, Sounders, Phila. 1954

MEDICAL DIVISION
CORN PRODUCTS REFINING CO.
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You and Your AMA . . .

Some Highlights and Sidelights on What Your American Medical Association Is Doing in Its Extensive and Far-Reaching Program

THE Eighth County Medical Societies Civil Defense Conference will be held November 9-10 at Chicago's Morrison hotel. Sponsored by the AMA Council on National Defense, the Conference is designed to help local medical and health personnel plan their roles in disaster and civil defense emergencies. Congresswoman Martha W. Griffiths of Michigan will report on the status of national civil defense legislation which received considerable attention during the first session of the 85th congress. Mrs. Griffiths is a member of the House Committee on Government Operations and its Subcommittee on Military Operations.

Another highlight of the Conference will be reports on the experience gained through several test operational exercises conducted under simulated disaster conditions, including a critique of the national exercise "Operation Alert."

MEDICAL EDUCATION CONGRESS SET FOR FEB. 9-11

Problems confronting medical education in the rapidly changing scene will be the main topic of concern at the 54th annual Congress on Medical Education and Licensure February 9-11. Sponsored by the AMA Council on Medical Education and Hospitals, the Federation of State Medical Boards of the United States and the Advisory Board for Medical Specialties, the Congress will be held at the Palmer House, Chicago. The conferees will view medical education's broad potential in the light of four factors—the changing characteristics of the nation's population, sociological trends, economy and medical knowledge—and the implications of these factors on medical education, medical research and medical care.

In addition, four workshop committees—composed of representatives from the AMA, the Council, the AAMC, higher education, government, business, insurance, labor and agriculture—will discuss various problem areas, endeavor to clarify questions that need to be raised and recommend possible ways that medicine can assume the leadership in solving these problems. The committees' reports will be presented before the entire Congress for discussion from the floor.

AMA COMMITTEES SCHEDULE MEETINGS

Two committees of the AMA Council on Medical Service plan regional meetings Monday, December 2, in Philadelphia just prior to the AMA's 11th Clinical Session. **The Committee on Maternal and Child Care**—first regional meeting on perinatal mortality and morbidity. Invitations are being sent to members of maternal and child care committees in Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia. **The Committee on Aging**—third regional conference for members of state committees on aging. Subjects to be discussed include physical examinations and a health maintenance program, guides for the organization and operation of medical society committees on aging, medical education in caring for the aged, preretirement counseling, and special research programs of a medical school.

Physicians interested in attending either of these sessions should contact the Council for further details.

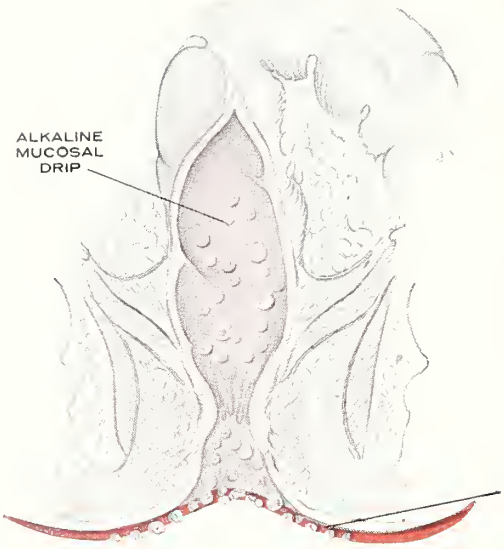
RESEARCH FOUNDATION IS SET UP

The American Medical Research Foundation recently was established by the AMA. Principal purposes of the Foundation will be: (1) to promote the betterment of public health through scientific and medical research; (2) to plan and initiate scientific and medical research, and (3) to collect, correlate, evaluate and disseminate results of scientific and medical research activities to the general public. Voting members of the Foundation will be AMA trustees. Meetings will be held annually at the time of the AMA Annual Sessions.

ARRANGE FOR CANCER FILM BOOKINGS THROUGH AMA

Hope in the thought that 75,000 lives in America need not be lost needlessly to cancer each year is the theme of a dramatic educational film recently added to the AMA Film Library. Titled "The Other City," the film stresses the encouraging fact that doctors currently are saving one in three patients as compared with a previous one-in-four ratio. Setting of the film is Racine, Wisconsin. Four basic thoughts are developed: (1) Racine empty and lifeless; (2) a symbolic representation of what cancer is; (3) how the 75,000 inhabitants of this token city could have helped save themselves, and (4) Racine alive and bustling.

Produced by the American Cancer Society, the 16mm. color film runs 22 minutes and 30 seconds. It is suitable for showings on local television as well as for church, club and school gatherings. Medical societies may book the film through the AMA Film Library.



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Whatever the Etiology . . .
Whatever Adjunctive Measures are Needed . . .

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1. Arthur, R. P., and Shelley, W. B.: A.M.A. Archives of Derm. **76**:296 (Sept.) 1957. 2. Ehrlich, R.: Am. J. Proctol. **7**:497 (Dec.) 1956. 3. Slocumb, L. H.: Am. J. Digest. Dis. **10**:227 (June) 1943. 4. Bacon, H. E.: Anus Rectum Sigmoid Colon, Diagnosis and Treatment, Philadelphia, J. B. Lippincott Co., 1949. 5. Bodkin, L. G., and Ferguson, E. A., Jr.: Am. J. Digest. Dis. **18**:59 (Feb.) 1951. 6. McGivney, J.: Texas J. Med. **47**:770 (Nov.) 1951.

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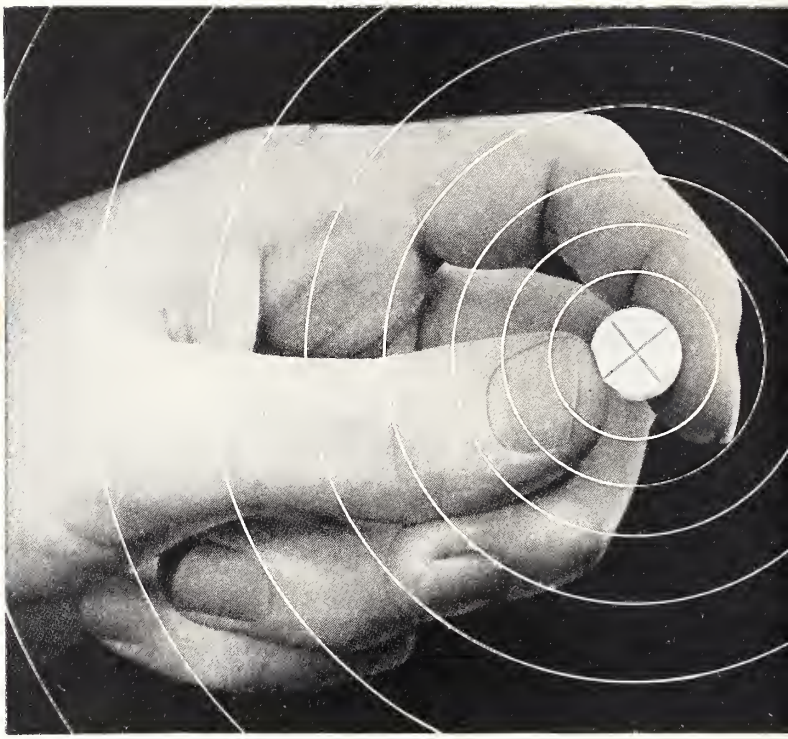
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Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

[1] Nichols, R. L. and Finland, M.: J. Clin. Med. 49:410, 1957.

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*Reg. U. S. Pat. Off.

The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Professional Public Relations and Political Power, by Stanley Kelley, Jr. ($4.50. *Johns Hopkins Press, Baltimore 18, Md.)* Every time you hear a political candidate speak on the radio, see him on television, read about him in the newspaper and magazines, the chances are that his appearance in person or in print is a part of a well thought out plan utilizing all of our modern knowledge of psychology and engendered by an entirely new kind of "politician"—the mass communications expert. The author, a fellow of the Brookings Institute, has carefully investigated this radical change, described it for us and interpreted what it will probably mean to our political future.

Treatment of Migraine, by John R. Graham, M. D. ($4.00. *Little Brown & Co., Boston 6, Mass.)* This is a review of the whole subject bringing the reader quickly up to date with current concepts. The author emphasizes the treatment of the acute attack and the prophylaxis against a recurrence.

Analgesia for Midwives, by Hilda Robters. ($3.50. *E. & S. Livingstone, Ltd., Edinburgh, Scotland*, U. S. Distributors, *Williams & Wilkins, Baltimore, Md.)* This is a small book telling midwives what they should know about obstetric analgesia in simple terms and in an informal style.

Pulmonary Emphysema, edited by Alvan L. Barach, M. D., and Hylan A. Bickerman, M. D. ($10.00. *Williams and Wilkins, Baltimore 2, Md.)* Eighteen authors, all expert in the subject which they discuss, contribute to this completely up-to-date work on the treatment of pulmonary emphysema. From the outline of treatment as it is programed at New York Presbyterian Hospital by Doctors Barach, Bickerman, and Beck the reader gets a consistent overall view of the medical management. The other chapters, other physicians fill with the single phases of therapy in detail.

Hutchison's Food and the Principles of Dietetics, revised by V. H. Mottram, M. A., and George Graham, M. D. ($8.25. 11th edition. *Edward Arnold Ltd., London, England*, U. S. Distributor, *Williams and Wilkins, Baltimore 2, Md.)* A standard text which has been serving the public for 46 years, it has always held a pre-eminent position among books dealing with food and the science of nutrition. Much has happened in the last nine years since the tenth edition. This edition has been thoroughly revised and brought up-to-date.

Psychology, Evolution, and Sex, by Cecil P. Martin, Sc. D. ($4.75. *Charles C. Thomas, Springfield, Ill.)* It is the contention of this book that the mutation-selection theory is unsustainable and that the usual genetical approach to the problem of the mechanism of evolution is too narrow and speculative. The author therefore attempts to approach the problem from a new angle. While written primarily for biologists, the text is designed to appeal and be intelligible to the general public. The author, head of Anatomy at McGill, points out that his alternative theory explains the biological significance of *bi-sexual* reproduction and accounts for the prominent place which sex holds in Nature.

The Lung as a Mirror of Systemic Disease, by Eli H. Rubin, M. D. ($12.50. *Charles C. Thomas, Springfield, Ill.)* This monograph alerts us to the wealth of information to be found in a chest x-ray. The head of Pulmonary Diseases at Monteflore Hospital, New York, shows how the lung may in some 80 diseases serve as a mirror reflecting what is going on in the organs and tissues of the body not accessible to direct examination. This treatment of the chest x-ray in these diseases is accompanied also by adequate treatment of the basic features of the particular disease so as to give a well rounded picture of it from the viewpoint of the differential diagnosis.

Slit Lamp Gonioscopy, by G. Gorin and A. Posner. ($7.00. *Williams and Wilkins Co., Baltimore 2, Md.)* There are not many textbooks of gonioscopy available although this method has gained great significance in diagnosis and surgery of glaucoma and other eye diseases. The present authors succeeded in writing a short but extremely instructive treatise, comprising history of the method, anatomy, and embryology of the structures to be examined, description of the armamentarium and its use. Further chapters are devoted to gonioscopic findings in normal eyes, in different types of glaucoma, inflammations, tumors, and traumatic conditions of the chamber angle. The role of gonioscopy in determining therapeutic and surgical indications is outlined. Clear illustrations and a glossary will be helpful for the student who can find additional information by using the very complete literature references.—(K. W. Ascher, M. D., Cincinnati, Ohio.)

Sleep—The Way to Sound and Healthful Slumber, by Marie Stopes. ($3.00. *Philosophical Library, Inc., New York 16, N. Y.)* The author famous for her books on sex now turns to sleep. She contributes many useful new facts, not enlivened by her controversial ideas which should be of the utmost interest to everyone.

Oral Cancer and Tumors of the Jaws; A Guide for the Diagnosis, by George S. Sharp, M. D., W. H. Bullock, M. D., and John Hazlet, D. D. S. ($15.00. *Blakiston Division, McGraw-Hill Book*

Co., New York 36, New York.) This is a comprehensive ready guide for the diagnosis of oral cancer and emphasis is put upon the early diagnosis and seemingly harmless lesions.

Human Perspiration, by Yas Kuno, M. D. ($9.50. *Charles C. Thomas, Springfield, Ill.)* This classic work in Physiology and Anatomy offers many valuable suggestions for clinical application.

Jane Arden, Registered Nurse, by Kathleen Harris. ($2.50. *Avalon Books, 22 E. 60th Street, New York 22, N. Y.)* We left her as a student nurse, now she is "faced with the prospect of employment in a position in a city-county hospital in Ohio." She had completed her training so she could remain at home but her sister insists that Jane come to Florida. She meets her old friend, David Hyatt who is now a jet pilot in the Air Corps and formerly "the boy next door," who makes her promise to marry him immediately and give up her nursing career. We have a conflict that makes the plot.

How to Pick the Right Climate, by Richard M. Page, Ph. D. ($1.00. *Martin Publishing Co., 4333 N. Tripp St., Chicago 41, Ill.)* This is an objective guide to the climate in the United States by the developer of thermidity technique for rating climatic comfort.

History of Nursing Notebook, by Elizabeth Jamieson and Mary F. Sewall. ($3.25. *J. B. Lippincott Co., Philadelphia, Pa.)* This is the 10th edition of the notebook containing new material on nursing organizations, nursing services, nurses in Canada, industrial nursing and the present trends.

Experimental Pharmacodynamics, by T. Koppanyi and A. G. Karczmar. ($5.00. *Burgess Publishing Co., Minneapolis 15, Minn.)* This is a study of the effect of drugs upon the living organisms with particular reference to man. This manual attempts to acquaint the reader with the experimental approach to this science.

Proceedings of the World Congress of Anesthesiologists. (Apply. *Scheveningen, Netherlands* United States distributor, *Burgess Publishing Co., Minneapolis 15, Minn.)* This volume contains the papers presented at the 1955 Congress.

A Manual of Practical Obstetrics, by the late O'Donel Browne and rewritten by J. G. Gallagher, M. D. ($7.50. Third edition. *John Wright and Son Ltd., Bristol,* United States distributors, *Williams & Wilkins, Baltimore 2, Md.)* This represents the current teaching of the Dublin School especially that of the National Maternity Hospital.

The Hostile Mind, by Leon J. Saul, M. D. ($3.50. *Random House Inc., New York 22, N. Y.)* This is a discussion of the sources and consequences of rage and hate—man's most destructive emotions. The emphasis is put on the future implications of the attitude adopted in childhood for coping with hostile feelings. Children can be guided away from unhealthy aggressive ways towards emotional maturity. In this way it is possible to establish a happy family and peaceful society.

Fitness for Secondary School Youth, edited by Karl W. Bookwalter and Carolyn W. Bookwalter for the American Association for Health and Physical Education. ($2.50. *N. E. A., 1201 16th Street, N. W., Washington, D. C.)* All of us who are interested in health will be interested in this report of the methods that should be used in the secondary schools to obtain the objectives for total fitness, welfare and self-realization of today's youth.

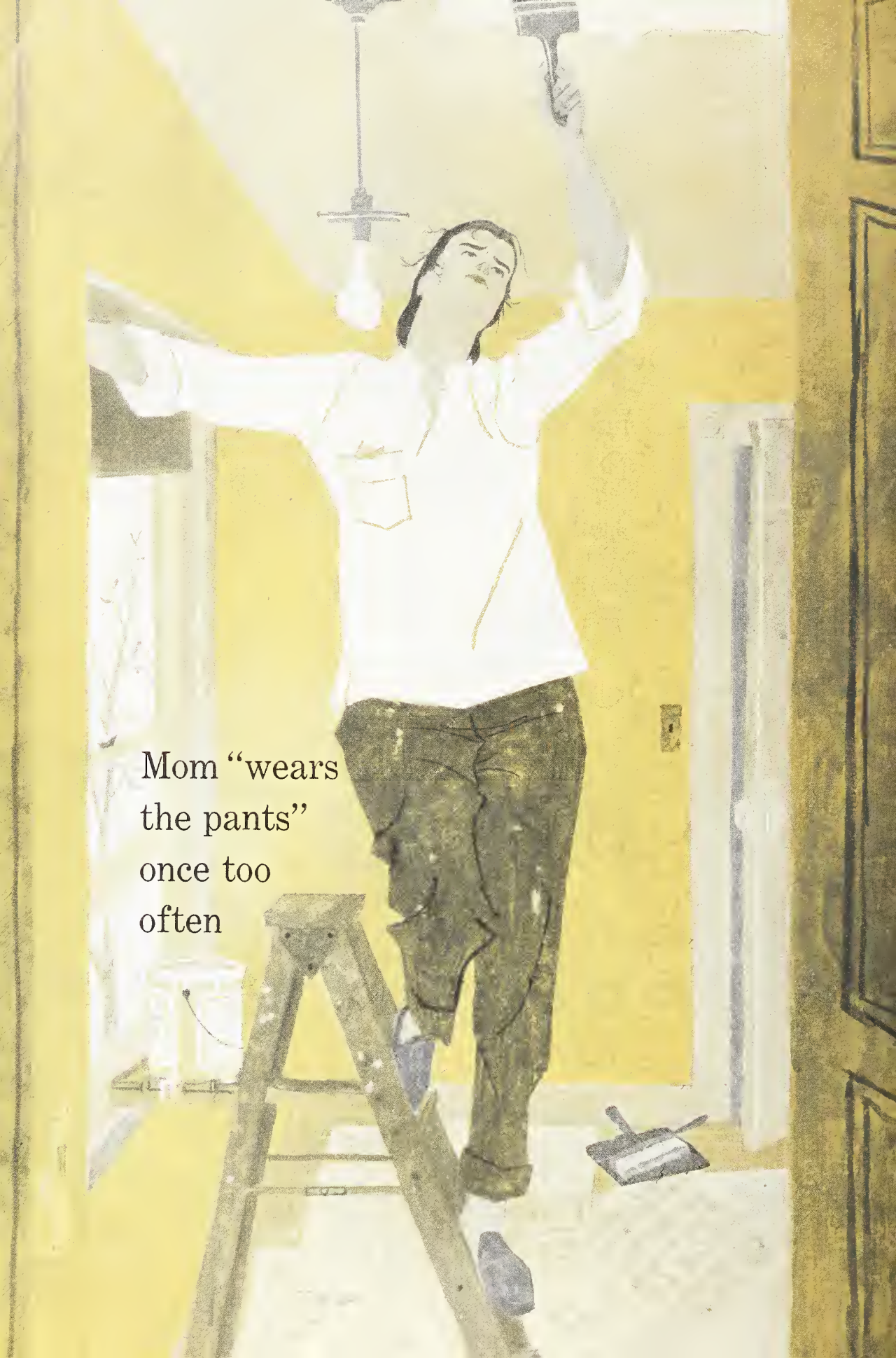
Management of Emotional Problems in Medical Practice, edited by Samuel Liebman, M. D. ($5.00. *J. B. Lippincott Co., Philadelphia 5, Pa.)* In this compact and lucidly written volume the editor has had the cooperation of nine well known physicians. They have pooled their broad knowledge and experience to bring us this invaluable advice on this increasing subject.

An Introduction to the Statistics in The Medical Sciences, by H. C. Batson, Ph. D. ($3.00. *Burgess Publishing Co., Minneapolis 15, Minn.)* This is essentially a series of lectures which have been given in certain professional schools. It is intended primarily for those of us who are lacking extensive background in mathematics.

Outline of Orthopaedics, by John Crawford Adams, M. D. ($7.00. *E. & S. Livingstone, Ltd., Edinburgh, and London England,* United States distributors, *Williams & Wilkins, Baltimore, Md.)* This book is intended primarily to help students for the qualifying examinations.

New Bases of Electrocardiography, by Demetrio Sodi-Pallares, M. D., with collaboration of Royall M. Calder, M. D., editor of the English translation. ($18.50. *C. V. Mosby, St. Louis 3, Missouri.)* This text has had a most unusual sale. It brings together the various bases upon which the whole subject rests. These for the most part have been widely distributed in the various sciences. It is not a treatise on clinical electrocardiography but a book which concerns itself with the "hows" and "wherefores."

Dermatology, by D. M. Pillsbury, M. D., W. B. Shelley, M. D., A. M. Kligman, M. D. ($20.00. *W. B. Saunders Co., Philadelphia 5, Pa.)* This book presents an approach to skin disease that should be most helpful to the physician possessed of reasonable familiarity of the Anatomy, Physiology and Chemistry of the skin. If at initial examination the skin lesions of the patient can be classified as common or uncommon, banal or serious, local or systemic, management can be accomplished in the way of diagnosis. To help those of us who have had little experience, this book has been written.


Mom "wears
the pants"
once too
often

frozen shoulder

Bursitis and tenosynovitis are new terms to homemakers, but they are not uncommon sequels to overexertion. Early antirheumatic therapy is to be encouraged in the treatment of these conditions, as it is in more serious rheumatic conditions, to alleviate pain and prevent progression of the disorder. With adequate therapy the prognosis of bursitis in its acute stage is good. Delaying therapy may result in extension of the inflammation and gross anatomical changes that tend to incapacitate the patient.

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Flu Fight

Drug Firms Speed Vaccine Output, Bu Will the U.S. Need

Asiatic Virus Raises Th Government Buys, F nd Hens Have to He

en Attack, Rapid Sp

8 STUDENTS ON FLIGHTS TO U. S. HAVE ASIAN FLU

New York, Aug. 15 (AP) Laboratory tests on e foreign exchange student arrived Aug. 8 show they victims of Asiatic flu, the health department repo today. The eight arrived plane from Europe.

Twenty-nine other stud suffering from influenza rived Tuesday from Rot dam on the ship Arosa Sky. One, Nicholas Memmos, Greek exchange student, die yesterday. Six of these students were released today the others are to be re tomorrow. It has not termined whether died from Asiatic

Pez vac izat flov the ority States

THE INFLUE

How Deadly Will it
What Can We Do a

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Asian Flu: the Outlook

Asian influenza will hit the U.S. this fall before mass immunization can be effective, and the nation faces an epidemic which may strike 15 million to 30 million people. The disease is relatively mild (in no way comparable to the killing "Spanish flu" of 1918-19), and is likely to cause only a small number of deaths among the feeble young and enfeebled old. But it may compel 10% to 20% of the population in affected areas to tak thus

W quie a co pect Ser pop

U.S. Fighting A

The War On Asiatic Flu

There's cause for concern about Asiatic flu, but scientists and public health officials see no reason for anyone to panic.

First shipments of the vaccine against the new influenza strain have arrived in Chicago, setting off a flood of telephone calls from worried patients to doctors, and from doctors to drug suppliers. This is a norm pattern of mass fear and is understan The of the

Even though Salk vaccine priorities were necessary, the regulation produced administrative headaches, public complaints and probably a gray, if not a black market. When regulation i invoke it. would h

PUBLIC HEALTH

Influenza M

➤ INFLUENZA, one of the most dictable of communicable diseases, ing "on cat feet" across the natio now. It has already struck once th in mild epidemic form at an Air base in Colorado. When and how s it will strike again is a perennial ri public health authorities.

It will probably not lie dorma the rest of the winter months. At th there will be sporadic outbr

to counteract
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ATCH "ASIATIC" FLU—

e New Virus Threat From Orient

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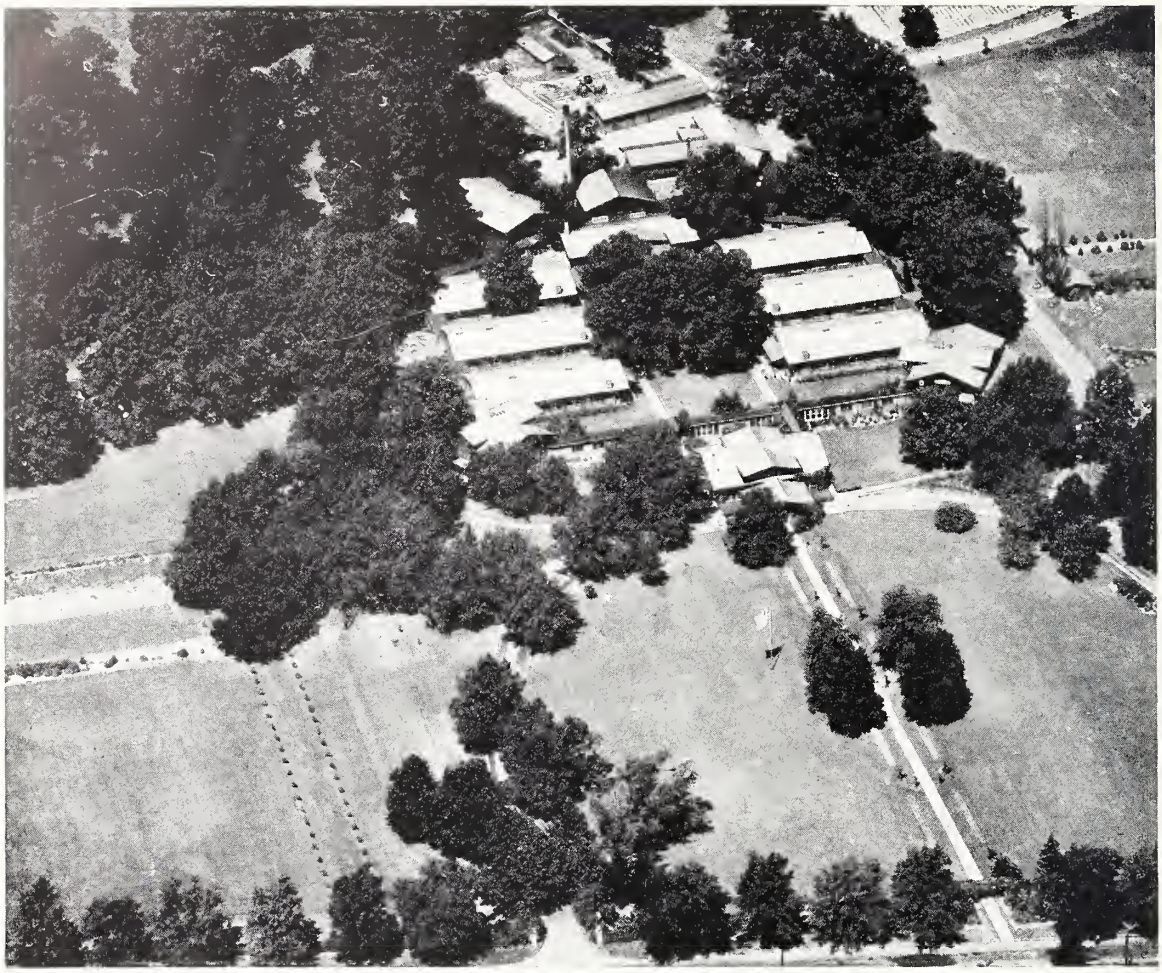
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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

SALE OF FLU VACCINE DIRECT TO LAY GROUPS CONDEMNED

Apparently, some manufacturers of the new influenza vaccine and some industries are doing their level best to confuse, complicate and butcher up the plans which have been devised to have the immunization program done in orderly fashion and get the vaccine first to high priority persons.

In many communities, industry appears to be able to get the vaccine; physicians are getting only a dribble—if any. Little or no respect is being shown for priority recommendations.

This, obviously, is causing plenty of trouble and bad feeling. This situation was predicted in these columns in the September issue. It's a shame it had to happen. Steps to stop the cause should be taken at once.

The Cleveland Academy of Medicine on October 8 adopted and issued a strongly worded resolution on this problem. We wholeheartedly agree with the statement. Here is what the resolution said.

WHEREAS the Academy of Medicine of Cleveland has recommended priorities to be followed while a shortage exists in Influenza A "Asian" strain vaccine; and

WHEREAS these priorities, based on recommendations by the Surgeon General of the United States Public Health Service, are designed to best assure the well-being of the public and the protection of the individual; and

WHEREAS "Asian" influenza is a relatively mild disease; and

WHEREAS it has become apparent in past weeks that the bulk of the vaccine being released commercially is passing directly into the hands of industrial and other low priority groups for mass programs which often include not only employees but also their families; and

WHEREAS vaccine is not available for high priority groups to the extent that the well-being of the community and the lives of the chronically ill may be in jeopardy; now therefore

BE IT RESOLVED that the Board of Directors of the Academy of Medicine of Cleveland disapproves of all programs to immunize low priority groups while the vaccine is in short supply; and

BE IT FURTHER RESOLVED that the Board of Directors request all members of the Academy of Medicine of Cleveland to refuse to participate in immunization programs for low priority groups while the vaccine is in short supply; and

BE IT FINALLY RESOLVED that in the opinion of the Board of Directors the sale of the vaccine directly to lay persons, non-medical organizations and corporations definitely constitutes a breach of ethics.

HEALTH CARD PROGRAM HAS MUCH MERIT

Some of the local Woman's Auxiliaries in Ohio are sponsoring a personal health information card-carrying project which has several notable assets. The idea originally was worked out jointly between the AMA Council on Rural Health and the Associated Women of the American Farm Bureau, including the Farm Bureau Women of the Ohio Farm Bureau.

The card—of wallet size—in addition to carrying the usual facts of identity, carries places for the name of allergies, blood type, time of cortisone medication, if any, vaccinations and dates, recent illnesses, surgery, etc.

Such information could be of great value to a physician, nurse, first aid person, or police in case of accident to the bearer of the card when he or she might be in shock or unconscious. Moreover, it serves as an indirect stimulant to the individual to keep tab on his health and see that his health record is in line with accepted procedures.

THE NEW SCHOOL YEAR AND RECRUITMENT OF HEALTH PERSONNEL

County Medical Societies and their Auxiliaries, as well as others interested in recruiting more personnel for the health fields, are confronted with a challenge which is set forth ably in the following statement published in September by the Committee on Careers of the National League for Nursing:

"As schools opened their doors this month, teachers groaned under the impact of such a student load as they had never experienced before. What worried communities and their school officials (more than the possibility of an Asian flu epidemic among school children) was how to find time, space and teachers to educate the largest junior and senior high school classes in history. The chance for an education through high school for American children was being challenged by this simple statistic: A 13 per cent rise in secondary school enrollment since 1955.

"Recruitment workers concerned with interesting young people in careers after high school are encouragingly predicting that today's pressing high school problem augurs a healthy personnel potential for their futures.

"Just as predictable is the fact that this increase in high school enrollment will bring about changes in methods of recruitment. Crowded classrooms, split shifts, late day classes and added teacher-counselor responsibilities are not apt to create a climate in which competitive recruitment activities for high school graduates will be welcomed. Careers activities must be planned and carried out with the problems of the high schools in mind if boys and girls are to have the guidance they need to select careers

wisely and if nursing is to attract enough students.

"Cooperative recruitment patterns that have flourished in nursing careers promotion more and more point the way to working within the pressure setting of the high schools. In some communities, these are coordinated recruitment activities for all professional nursing schools in the area; in others, a broad interest that includes both practical and professional nursing; in still others, cooperative programs with other health disciplines. 'Togetherness' saves the time of busy counselors and teachers and encourages individual guidance of students."

THIS INVESTIGATION COULD ACCOMPLISH MUCH

It isn't often that a report of a forthcoming Congressional investigation attracts much interest. but one reported in the AMA Washington newsletter is, in our opinion, an exception to the rule.

Pending is a House subcommittee investigation of executive departments and agencies, to attempt to determine if, in administering laws, they are staying within the intent of Congress or expanding their authority.

As the subcommittee chairman explains it, the objective is to learn if laws have and are being "faithfully executed . . . in the public interest," and if laws and standards they contain "have and are being interpreted by rule or internal procedures to enlarge the area of regulation beyond that intended, and to administer them through procedures not intended by the Congress," So said Rep. Morgan M. Moulder (D. Missouri).

Those who have had more than a passing acquaintance with governmental operations are not unfamiliar with the practice of "pyramiding." This practice involves the art of creating and artificially expanding new tasks and duties within the department section or agency. New tasks, duties and projects require additional funds and personnel. This expansion elevates the head of the agency to a loftier perch, his immediate subordinates to relative positions.

The results of this investigation bear watching.

ANNOUNCEMENTS ON OPENING OFFICE—ETHICAL OR UNETHICAL?

Here's a question frequently asked by a physician—usually the young man just starting practice:

"To whom may announcements concerning the opening or removal of a doctor's office be made and is there a p r e s c r i b e d form for such announcements?"

Here's what the Judicial Council of the AMA has to say on this double-barrelled question:

On opening an office a physician may properly send announcements to his colleagues, to his intimate personal friends not in the medical profession, and to those persons in allied fields with whom it may reasonably be expected he will associate. Announcements of the opening of an office should not be mailed indiscriminately to all persons in the community, nor should commercial mailing lists be utilized. A brief news item carried in the local press, in itself, is not unethical. Local societies may, however, in the exercise of good judgment determine and fix limitation in this regard.

On removing an office a physician may properly advise of this fact to the same persons and in the same manner as he may announce the opening of an office. In addition, he may, and should, advise his patients of the essential facts concerning this removal. In any case, the physician is well advised to check with the appropriate officer or committee of his local medical society in order to conform his conduct with local practice.

No form has been approved by the American Medical Association. Under the Principles of Medical Ethics and in keeping with the ideals of the profession, it would seem that no objection would be made to a simple statement of fact, without undue embellishment. * * * In all cases the local society can be looked to for an authoritative opinion.

ACTION BACK HOME BETTER THAN A LOBBY

Raymond Moley in his recent column on "What Is A Lobby?" observes that "politicians in Congress or elsewhere, are generally moved not by abstract arguments about legislation, but by how many votes the man who is arguing can produce."

Moley continues: "It is my considered opinion that about 85 per cent of the money that businesses and their trade organizations spend on Washington lobbies is wasted. In short, no cocktail party, however stimulating, or chart or speech, however logical, can overcome the lack of activity at home."

On numerous occasions, in *The Journal* and in OSMA bulletins have appeared the words: "Votes are made back home." Offices in Washington —and Columbus—play an important role in keeping tab on legislation but they are only a part of the machinery. The biggest role must be played by people back home who are the voting constitutents of members of Congress and the Ohio General Assembly.

Keep these facts in mind the next time there is an election; the next time a legislative proposal which you like or don't like is about to be acted upon. Express your views. Express them at the polls or to your elected representative. Don't wait for some office some place to do the job which rightfully must be done by you—and can be done more effectively by you in the long run.

FOR THE ENTIRE RANGE OF RHEUMATIC-ARTHRITIC DISORDERS—from the mildest to the most severe

many patients with MILD involvement can be effectively controlled with

'MEPROLONE'

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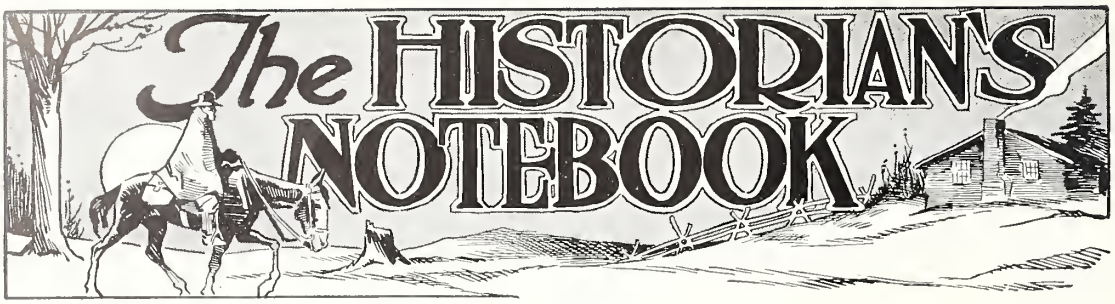
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the one antirheumatic, antiarthritic that simultaneously relieves: (1) muscle spasm (2) joint inflammation (3) anxiety and tension (4) discomfort and disability.

SUPPLIED: Multiple Compressed Tablets in three formulas: 'MEPROLONE'-5—5.0 mg. prednisolone, 400 mg. meprobamate and 200 mg. dried aluminum hydroxide gel. 'MEPROLONE'-2—2.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel. 'MEPROLONE'-1 supplies 1.0 mg. prednisolone in the same formula as 'MEPROLONE'-2.

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Samuel Mitchel Smith, M. D., Medical College Psychiatric Lamplighter

PHILIP C. ROND, M. D.

PART I

THE AMERICAN JOURNAL OF INSANITY in October, 1847, noted the first appointment of a professor of psychiatry in a medical school in the United States as follows:

"We are gratified to learn that a Professorship of Insanity has been established at one medical school. The Willoughby University, Columbus, Ohio, has appointed Samuel M. Smith, M. D., Professor of Medical Jurisprudence and Insanity. We think there should be a distinct course of lectures on mental maladies at every medical school. Dr. Smith has some practical knowledge of insanity, having been an assistant physician at the Ohio Lunatic Asylum for several years."[1,2] *The American Journal of Insanity* had only begun publication in 1844. It was edited by Dr. Amariah Brigham and his fellow officers of the New York Lunatic Asylum, Utica, New York. This is the journal which eventually became the official journal of the American Psychiatric Association.

THE EARLY YEARS

Samuel Mitchel Smith was an Ohioan, a true Buckeye from beginning to end. He was born in Greenfield, Highland County, Ohio, on November 26, 1816. His father, Samuel Smith, Sr., owned and operated a tannery there. His mother, Nancy Mitchel Smith, is said to have been one of the first babies born in that pioneer community. The historic, two-story, stone house occupied by the family is still standing on the northwest corner of Front and Main Streets in Greenfield.

Samuel Smith's early education was obtained from private schools and from his father, who in addition to operating a tannery was also the Presbyterian minister in the community. In his early teens, he obtained a position as a teacher in the district schools of Greenfield, and by a frugal accumulative existence saved sufficient funds to matriculate at Miami University, Oxford, Ohio, in 1832, from which he obtained his A. B. degree in 1836.

Following his graduation from Miami University in 1836, he was appointed principal of an academy at Rising Sun, Indiana. This position he had obtained through the recommendation of his friend William Holmes McGuffey, professor of Latin and Greek at Miami University, and the man whose name was a household word among several generations of Americans because of his authorship of the *McGuffey Eclectic Readers.*

He read medicine while at Rising Sun under Dr. John Morrison, and attended two sessions of medical lectures at the Medical College of Ohio in Cincinnati. He obtained an M. D. degree from this college in 1839.[3] He enrolled at the University of Pennsylvania Medical School, Philadelphia, Pa., in 1839 and obtained his second M. D. degree there in 1840.

PROFESSIONAL BEGINNING

Dr. Smith came to Columbus in 1840, and in August of that year he was appointed an assistant physician at the Central Ohio Lunatic Asylum (Central Ohio Hospital For The Insane), under the supervision of Dr. William Maclay Awl. He remained at this position for approximately

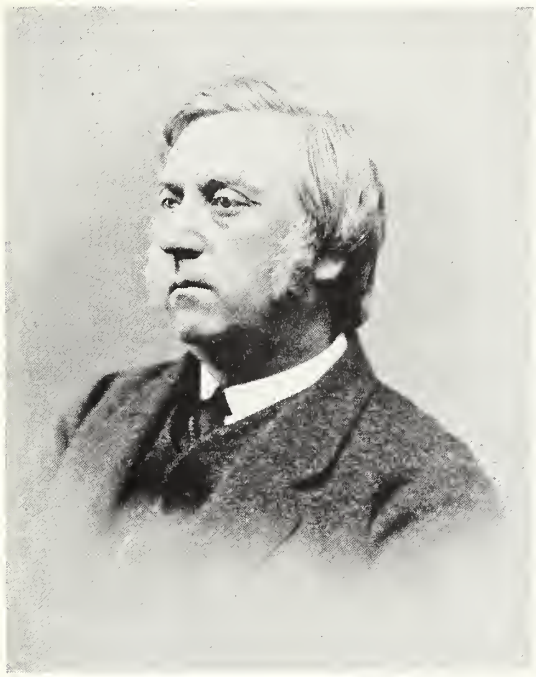
The Author

● **Dr. Rond, Columbus, is a member of the staff at Columbus Receiving Hospital and State Institute of Psychiatry; Department of Psychiatry, Ohio State University College of Medicine.**

Submitted June 17, 1957.

three years, until 1843, when he resigned and opened up a general practice on East Rich Street, near High Street in Columbus. He later removed his offices to 154 East State St., where he remained until his death. In 1843, the year he began his private practice, he married Susan Evans Anthony, the daughter of General Charles Anthony of Springfield, Ohio, who was a prominent attorney and who had served four terms in the Ohio Legislature.[3]

On February 19, 1847, the trustees of the Medical Department of Willoughby University



SAMUEL MITCHEL SMITH, M. D.
(1816-1874)

met in Columbus. They resolved that the Medical Department should be removed to the city of Columbus in the State of Ohio. They subsequently declared all chairs in the Medical Department vacated, and then proceeded to fill these vacated chairs with new appointments. Among those appointed unanimously was Samuel Mitchel Smith, M. D., of Columbus, to the chair of Medical Jurisprudence and Insanity. Dr. John Butterfield was appointed dean of the faculty. From this point on, Dr. Smith's name is closely associated with medical education in Columbus and Ohio. He maintained a close working relationship with psychiatry throughout his entire medical career.[4]

STARLING MEDICAL COLLEGE TIES

In 1848 the Starling Medical College was founded, and Willoughby Medical College, of Columbus, merged with it and discontinued its existence under the name of Willoughby. At this time, Dr. Smith was honored with two appointments. He was appointed a member of the Board of Trustes by Mr. Lynn Starling, the benefactor of the Starling Medical College; he was also made professor of Materia Medica and Therapeutics, in addition to his previous appointment as chairman of the Department of Medical Jurisprudence and Insanity.

Two years later Dr. Smith was made professor of the Theory and Practice of Medicine, which position he maintained until ill health forced him to resign in 1872. He continued to serve as a member of the Board of Trustees until his death. He was held in great esteem by his associates on the faculty. He was appointed the second dean of the Starling Medical College, Columbus, Ohio, in 1849, and maintained this position until 1858. He resigned at this time only to return for a second term as dean from 1861 to 1865. Starling Medical College eventually became Ohio State University College of Medicine.[5, 6, 7]

The Ohio Medical and Surgical Journal, Vol. 1, 1849, contained the following notice about Starling Medical College: "The annual course of lectures will commence on the first Wednesday in November-next (November 7, 1849) and will continue sixteen weeks. The preliminary course will commence on the first Wednesday in October, during which month there will be three lectures daily. In October, the following subjects will be taught:

> "Minor Surgery, Dr. Howard; Insanity, Dr. Smith; Poisons, (illustrated by experiments on lower animals), Dr. Carter; Microscopic Anatomy, Dr. Gay; Physical Diagnosis, Dr. Butterfield.
>
> "*Signed*, S. M. SMITH, Dean of the Faculty."[8]

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(To Be Concluded in December Issue)

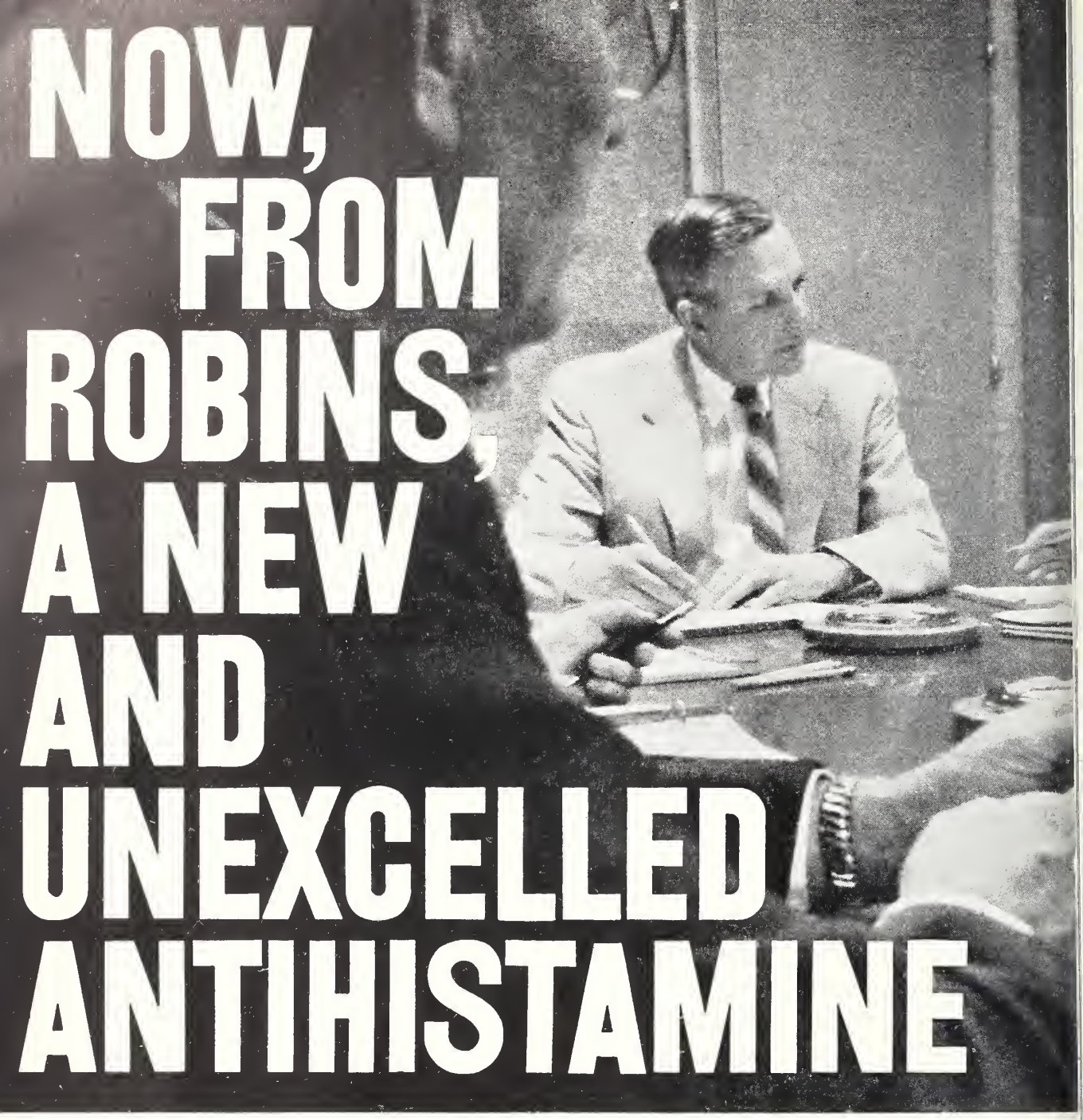
Wisconsin Physicians Plan Medical Museum

A 20-year dream of Wisconsin physicians to build the first museum devoted exclusively to the developments of medicine is nearing reality, according to a release by the United Press.

The Wisconsin State Medical Society revealed architectural plans for the medical museum, which is to be located near Prairie du Chien.

Dr. William D. Stovall, chairman of the society's historical section, said the museum will be built on the site of the old Fort Crawford Military Hospital where Dr. William Beaumont conducted pioneer research on the physiology of digestion 125 years ago.

NOW, FROM ROBINS, A NEW AND UNEXCELLED ANTIHISTAMINE



why Dimetane is the best reason yet for you to re-examine the antihistamine you're now using »

Milligram for milligram, DIMETANE potency is unexcelled. DIMETANE has a therapeutic index unrivaled by any other antihistamine—a relative safety unexceeded by any other antihistamine. DIMETANE, even in very low dosage, has been effective when other antihistamines have failed. Drowsiness, other side effects have been at the very minimum.

» unexcelled antihistaminic action

Diagnosis	No. of Patients	Response				Side Effects
		Excellent	Good	Fair	Negative	
Allergic rhinitis and vasomotor rhinitis	30	14	9	5	2	Slight Drowsiness (3)
Urticaria and angioneurotic edema	3	1	1	1		Dizzy (1)
Allergic dermatitis	2		1	1		Slight Drowsiness (2)
Bronchial asthma	1		1			
Pruritus	1		1			
Total	37	15	13	7	2	Drowsiness (5) Dizzy (1) 16.2%

From the preliminary **Dimetane Extentabs** studies of three investigators. Further clinical investigations will be reported as completed.

The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit organization, with a definite membership, for scientific and educational purposes.

Vol. 53 November, 1957 No. 11

JONATHAN FORMAN, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

Pitressin® Toxicity in Diabetes Insipidus, and the Therapeutic Superiority of the Nasal Route for Replacement Therapy. (Report of a Case)

WARREN W. SMITH, M. D.

THE polyuria of diabetes insipidus is frequently but not always controllable by the administration of posterior pituitary extract. Insufficient emphasis has been given to the toxic effects of the over-zealous administration of posterior pituitary extract which may characterize the management of cases exhibiting resistance to this medication. Moreover, the frequent therapeutic superiority of administration of extract by the nasal route is not widely appreciated. Therefore, the following case is reported. This is a young man with acquired diabetes insipidus who responded incompletely to parenterally administered Pitressin®, and who developed severe hyponatremia during this attempt at therapy. His polyuria was subsequently completely controlled without toxicity when posterior pituitary powder was given by nasal insufflation.

The Author

● Dr. Smith, Columbus, is Associate Physician at the Columbus Medical Center and on the faculty of the Department of Medicine, The Ohio State University College of Medicine, and on the staffs of White Cross, University and Mt. Carmel Hospitals.

REPORT OF CASE

The patient was an 18 year old colored male who was admitted to the hospital on May 17, 1954, with the complaints of polyuria and polydipsia of seven months' duration. No abnormalities were found on physical examination, either by the present writer or a neurologist. A random sample of urine was colorless, had a specific gravity of 1.001 and was otherwise unremarkable. Complete blood count, CO_2 combining power, serum or blood concentrations of cholesterol, urea nitrogen, sugar, sodium, potassium and chloride were normal. Also normal were spinal fluid, x-rays of the skull and the entire bony skeleton, intravenous pyelogram (done after the administration of 10 units of aqueous Pitressin), phenolsulfonephthalein dye excretion, and endogenous creatinine clearance.

During a fluid fast the patient's urine volume remained high: by the end of 12 hours it had amounted to four liters, and the serum concentrations of sodium and packed red cells had risen by 15 per cent. The Hickey-Hare test revealed unresponsiveness of urine flow to administered hypertonic saline. Following the intravenous administration of 10 units of aqueous Pitressin to the hydrated patient, there was abrupt reduction of urine flow to normal.

From this study it was concluded that the patient had diabetes insipidus of unknown etiology. He was permitted to be ambulatory and to drink fluids ad lib. The 24 hour urine output ranged between 11 and 15 liters (See the figure). On June 12 Vasopressin Injection U. S. P. (Pitressin) administration was initiated in dosage of 3 units (0.15 cc.) thrice daily. There was immediate reduction of urine volume to about 7 liters

Submitted July 1, 1957.

per day. On June 17, the dosage was increased to 5 units (0.25 cc.) four times a day but the average daily urine volume exhibited little if any significant further change.

The serum sodium, normal at first, was observed closely, and on June 22 was found to have fallen to 127 mEq./L. At this point Pitressin was discontinued. The urinary volume returned practically to the previous control values. The serum sodium concentration fell further to 113 mEq./L. by June 25, but spontaneously returned to normal by June 28. No weight change had accompanied this trial of therapy, and no symptoms attended the hyponatremia.

On July 15, Solution Pitressin Tannate in Oil, N. N. R., was administered intramuscularly in a dosage of 5 pressor units (1 cc.). The urine volume fell on that day to 2 liters, was 3 liters the following day, but rose to 7 liters the day after. This same dose was repeated on July 18 and on each second day thereafter. The patient's responsiveness to this regimen diminished, however, and on one occasion (July 28) the urine volume was 7 liters during the 24 hours immediately following the administration of the medication. Although serum sodium, potassium and chloride concentrations were checked frequently, there developed no change in these constituents.

It was concluded that the patient was moderately resistant to parenterally administered Pitressin and that quantities of this medication sufficient to reduce significantly the urine volume would be excessive and toxic. Because an occasional patient with diabetes insipidus resistant to injected posterior pituitary extract responds well to nasally insufflated posterior pituitary powder, medication was changed to this form and route. A small pinch* of Posterior Pituitary, U. S. P. (powdered desiccated posterior pituitary gland) was placed in a DeVilbis Spray No. 44 and blown into the nostrils as needed during the day. It was found that three applications per day controlled the urine volume satisfactorily. The patient was observed for about six weeks on this therapy and during that time remained asymptomatic and exhibited no electrolyte abnormality.

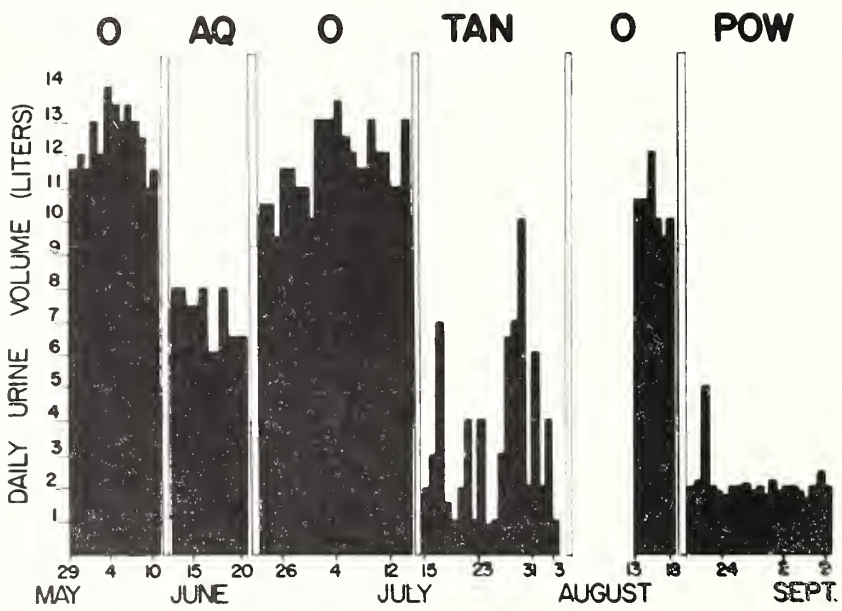
DISCUSSION

It has been repeatedly shown[1-5] that extracts of posterior pituitary having antidiuretic potency may affect renal electrolyte excretion as well as urine volume. The nature and extent of this influence apparently depends upon a number of variables, including species differences, dosage, types of extract, route of administration, and the time over which the extract is administered.

Acute studies[1,2] in man with single injections have shown that Pitressin in what is considered to be the usual pharmacological dosage (15 to 100 milliunits) causes typical reduction in urine flow but does not significantly alter the urinary excretion of sodium, chloride or potassium. Much larger single doses[3] (8 units in children), however, cause increased excretion of sodium and chloride, and a reduction in urinary potassium.

Farber, in unpublished observations, demon-

* Approximately 40 to 50 mgm.



The ordinate is the daily urine volume in liters. The values for this function are divided into six zones, each zone being separated by a vertical empty bar, respectively representing (1) no therapy, (2) administration of aqueous Pitressin, (3) no therapy, (4) administration of Pitressin Tannate in Oil, (5) no therapy, and (6) administration of posterior pituitary powder by the nasal route. The single value in excess of 2 liters in the last zone represents one day when an attempt was made to use two applications of powder rather than the three applications that proved to be necessary.

strated that when given over a period of days in rather high dosage to normal man, Pitressin Tannate in Oil (15 U daily) caused marked urinary sodium loss with hyponatremia developing in two to four days. In one subject the serum fell to 105 mEq./L. There was also a fall of serum chloride concentration but no change of potassium. Studies of total body sodium and water disclosed a reduction of the former and increase in the latter. Leaf and co-workers[4] using the same preparation but in doses of 2 to 3 units per 24 hours, also observed an increase in urinary sodium and chloride excretion, as well as water retention, but only in normally hydrated subjects; these changes could be prevented by restriction of fluid intake to less than 1 liter per day during Pitressin administration. These investigators suggested that the alterations in renal electrolyte excretion were not direct effects of Pitressin but were homeostatic responses to over-expansions of fluid volume.

The polyuria in most patients with diabetes insipidus can be controlled by the administration of 1 to 2 units of Pitressin daily. When a physician is attempting to control polyuria in a patient with resistant diabetes insipidus, the tendency is to increase progressively the dose of Pitressin. In such a patient, like the one presented here, it may not be possible to reduce the daily urine volume to normal even with doses of Pitressin which are physiologically massive. (It should be noted that such doses may represent only small portions of the usual commercially prepared single-use glass ampule of Pitressin, which contains 1 cc. or 20 units.) Under such circumstances, the sustained increased excretion of certain urinary electrolytes may promptly bring about a dangerous body electrolyte derangement.

Although it has been known for some time[6] that posterior pituitary powder taken nasally may completely control polyuria in some patients resistant to injected posterior pituitary extract, this phenomenon does not appear to be widely known to practicing physicians. The reason for this difference in effectiveness is unknown. In the present case posterior pituitary powder administered nasally was the only means for complete control of the urine volume and, in contrast with injected posterior pituitary extract, appeared to have therapeutic effect without toxic effect.

SUMMARY AND CONCLUSIONS

1. A young adult with acquired diabetes insipidus exhibited partial resistance to posterior pituitary extract given parenterally. Severe hyponatremia developed when the dosage of aqueous Pitressin was increased in an attempt to normalize the daily urine volume. Superior but still inadequate control of urine volume without adverse effect on serum sodium was obtained with single daily doses of Pitressin Tannate in Oil in lower daily unitage. Sustained complete control of urinary volume, without any toxic effects on electrolytes, was finally achieved by nasal administration of posterior pituitary powder.

2. Normally hydrated human subjects exhibit reduction of urine volume but no consistent change of renal electrolyte excretion following single clinical doses (well under 1 unit) of Pitressin. Larger single doses, especially when administered over several days, cause increased excretion of sodium and chloride and may cause systemic electrolyte derangements. These effects on electrolyte excretion may or may not be the *direct* effect of the hormone on the kidney.

3. It is important to use caution when "pushing" the dosage of Pitressin in patients with resistant diabetes insipidus, and to check the serum electrolyte concentrations frequently.

4. The magnitude of effect on electrolyte excretion of different preparations of posterior pituitary does not necessarily parallel the magnitude of their suppressant effect on urine volume.

5. For reasons presently not understood, nasally administered posterior pituitary powder may completely control the polyuria of cases of diabetes insipidus resistant to parenteral Pitressin, and may do so without the toxicity of the latter.

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Industrial Injuries Of Farm Workers

Most industrial employees receive physical examinations to evaluate their physical fitness in relation to their work.

The farm worker is neglected in this matter, in that he is hired for almost any type of work without physical evaluation. As a result, his accident rate is high. His efficiency at his work is low. His time loss from work because of sickness and accident is high, and the employer pays a very high rate of insurance for the patient's care and his own legal protection.

Physical fitness cards should be carried by all farm laborers to keep them in a kind of work suited to their physical condition. This would tend to prevent injury, increase efficiency and lower the cost of the care and protection of workers.—Donald P. LaTourette, M. D., Ceres, Calif.: *California Med.*, 87:142, September, 1957.

Community Detection of Diabetes

EARL E. LONG, M.S., and GEORGE JAMES, M.D., M.P.H.

THE modern health department believes that the study of technical and practical problems in chronic disease detection is a proper role of the official health agency in chronic disease control. The decision concerning which functions in such disease screening are the responsibility of private physician, hospital, private laboratory, official or voluntary agency can be left for later determination. At this stage all groups must cooperate to explore and evaluate, by small demonstration studies, the practical use of those tests which are now available. The Public Health Committee of the Summit County Medical Society has cooperated fully in the four diabetes detection study projects described in this report and illustrated in table 1.

STUDY A. 1954

URINE GLUCOSE DETECTION PROGRAM

At the Annual Health Day's Exhibit sponsored by the Woman's Auxiliary to the Summit County Medical Society, 7,975 Dreypak urine glucose detection test units were distributed to the general population. Those receiving the Dreypak kit were registered, including the name of the family physician. Of this group, 4,892 (61.3 per cent) returned the Dreypak kit by mail to the laboratory for analysis. The 61.3 per cent return was believed to indicate an exceptional degree of participant cooperation, due largely to the excellent public information program which accompanied the project.

Of the 4,892 tested, 257 (5.2 per cent) were positive for urine glucose and referred to their family physician. Follow-up data was reported on 161 (62.6 per cent) of these resulting in 18 previously known and 19 previously unknown cases of diabetes. The 19 new cases represented a yield of 0.4 per cent of those who submitted the tests to the laboratory.

STUDY B. 1955

URINE GLUCOSE DETECTION PROGRAM

In connection with the special detection project described in Study C below, Dreypak kits were also issued to 2,488 persons. Of these, only 814 (32.7 per cent) were returned and 25 (3.1 per cent) of these screened positive. Follow-up study of 22 of these revealed three new cases of diabetes, representing a 0.4 per cent yield of cases from among those who mailed the Dreypak test slips back to the laboratory for testing.

Submitted July 31, 1957.

The Authors

- Mr. Long, Akron, is Director of Laboratories, Akron City Health Department.
- Dr. James, Director of Health, Akron City Health Department, is presently Deputy Commissioner of Health, New York City.

STUDY C. 1955

CLINITRON BLOOD SURVEY

A three-way detection program consisting of a chest x-ray, serological test for syphilis and clinitron* blood test for diabetes was performed on 2,400 persons in two industries in Akron. The details of the entire pilot project are described elsewhere.[1] The Hewson Clinitron, which is based upon the Wilkerson-Heftmann method[2] of "true blood glucose" determination, can operate at the rate of two tests per minute, with each individual test taking five minutes. Each blood specimen is screened at the 130 mg. per 100 ml. blood glucose level, and if positive is checked again at the 180 mg. level. Incomplete or doubtful reactions can be detected at the 180 mg. level, indicating a blood glucose level somewhere between 130 to 180 mg. per 100 ml. It should be remembered that these numerical levels are about 20 mg. lower than the readings obtained by the more commonly used Folin-Wu method, which is less specific since its reading is also influenced by the variable amounts of non-glucose reducing substances in the blood.

Each person registering for the test was asked to record the length of time since he had eaten. All who gave a blood sugar reaction at the 180 mg. level and those who had both a blood sugar over 130 mg. and a history of no food consumption within one hour before the test were considered as positive. Those in this positive group were urged to go to their private physician for follow-up. There were 82 (3.4 per cent of those tested) in this positive group. Follow-up data was secured from 54 (65.9 per cent of those positive) and indicated five previously known and five new cases of diabetes,** a yield of 0.2 per cent new cases of the disease.

Several factors appeared in the three studies described in the foregoing which caused serious

*Loaned by the Public Health Service, Chicago Regional Office and the Ohio Department of Health.

**One of these was also detected by the urine glucose test done in Study B.

concern and can impair the scientific usefulness of the data collected. First, there was the inadequate (an average of two-thirds) follow-up of persons screened as positive. Despite all of our special efforts, many refused to visit their physician, name a family physician or name the correct physician.

Second, there was the lack of a required degree of standardization of the relationship between the test and prior food consumption.[3]

Third, there was the disturbing fact that follow-up examination usually seemed to consist of something less than the standard three hour glucose tolerance test. For example, only 12 per cent of those screened positive in Study C were given a glucose tolerance.

Fourth, there was the fact that such follow up blood sugar tests as were done did not employ a recommended "true glucose" method[4] like the Somogyi-Nelson.

Fifth, was the small number of diagnoses of "pre-diabetes" or "potential diabetes"*** which were reported by the physicians who were rechecking those screened as positive. Modern studies of diabetes detection have repeatedly stressed the significant number of these potential diabetics which are detectable and worth following, because they have a significantly higher risk of developing diabetes during later years.[5, 6] In Study A, none were reported; in Study B, only one and in Study C, three were found. In total, therefore, the three studies resulted in clinical diagnoses of 23 as known diabetics; 26 as new diabetics and only four as potential diabetics.

***The term "Potential Diabetic" is preferred to "Pre-Diabetic" since the latter suggests a progressive state, which is not necessarily true.

STUDY D. 1956

GLUCOSE CHALLENGE DOSE CLINITRON STUDY

Study D was devised to answer the five objections previously listed. The occasion of a city employees' picnic presented the opportunity to test a "semi-captive" group which could be easily reached by means of a standardized follow-up which the Health Department Laboratory was able to perform. Each participant was registered, given a 50 gram lemon-flavored mixture of glucose to drink and told to report back one hour later for the screening clinitron blood test. The blood was checked as in Study C at the 130 mg. per 100 ml. and 180 mg. per 100 ml. levels. Those positive at either level were asked to return without breakfast at a stated morning for a glucose tolerance test.

The test employed was the Somogyi-Nelson[7] with a fasting specimen and readings taken one, two, and three hours after the ingestion of a lemon-flavored solution of 100 grams of glucose.

Although no laboratory can or should make a "diagnosis" of diabetes from a laboratory test alone, the Public Health Service[8] has indicated the following formula for presumptive evidence of diabetes after an oral 100 gram glucose dose:

Specimen	If the Blood Glucose is Over	Count the Point Score as
Fasting	110 mg./100 ml.	1
1 hour	170 mg./100 ml.	$\frac{1}{2}$
2 hours	120 mg./100 ml.	$\frac{1}{2}$
3 hours	110 mg./100 ml.	1

If the total point score is 2 or greater, then laboratory evidence of diabetes exists. If the total

TABLE 1.—COMPARATIVE RESULTS OF THREE DIABETES DETECTION PROGRAMS

	A Dreypak 1954	B Dreypak 1955	C Blood 1955	D Blood 1956 Screened 130 mg./100 ml.	D Blood 1956 Screened ? 180 mg./100 ml.[1]
Total Tests Issued	7975	2488	2400	305	305
Total Tests Performed	4892	814	2400	305	305
% of Total	61.3	32.7	100	100	100
Total Screened Positive	257	25	82	41	16
% of Tests Performed	5.2	3.1	3.4	13.4	5.2
Follow-Up of Positive Reactors					
Total Followed	161	22	54	41	16
% of Positive	62.6	88.0	65.9	100	100
Total Diabetics	37	3	10	10	9
% of Tests Performed	0.8	0.4	0.4	3.3	3.0
% of Positives Followed	23.0	13.6	18.5	24.4	56.2
Known Diabetics	18	0	5	3	3
% of Tests Performed	0.4	0	0.2	1.0	1.0
% of Positives Followed	11.2	0	9.3	7.3	18.8
New Diabetics	19	3	5	7	6
% of Tests Performed	0.4	0.4	0.2	2.3	2.0
% of Positives Followed	11.8	13.6	9.3	17.1	37.5
Potential Diabetics	0	1	3	14	2
% of Tests Performed	0	0.1	0.1	4.6	0.7
% of Positives Followed	0	4.5	5.6	34.1	12.5
Persons Requiring Glucose Tolerance Follow-Up[2]	239	25	77	38	13
% of Total Tests Performed	4.9	3.1	3.2	12.5	4.3

[1] Positive at 130 mg. level and not completely negative at 180 mg. level
[2] Total screened positive less the known diabetics

point score is under 2 but greater than 0, then "potential diabetes" may be suspected.

Of the 305 who participated in this study, 41 (13.4 per cent) were screened as positive, 26 at the 130 mg. per 100 ml. level and 16 at the ? 180 mg. Follow-up with glucose tolerance or a medical history of previously known diabetes was obtained on all of the positive reactors, details of which are presented in table 2.

Although the numbers studied are small, the data are highly suggestive. The 41 positive gave 3 known and 7 new "cases" of diabetes for a total diabetes yield of 3.3 per cent (new cases 2.3 per cent)—from 4 to 10 times that of any of the other projects. In addition, 14 gave readings in the "potential diabetic" zone (34.1 of those screened positive).

If those who screened at the ? 180 mg. or higher level are studied, it is found that the yield of new cases was 6 (2.0 per cent of those tested). Only one case of diabetes, either known or new would have been missed if the ? 180 mg. screening level had been taken instead of the 130 mg. one. However, 12 of the 14 persons giving "potential diabetes" glucose tolerance readings would not have been detected. On the other hand, the expensive glucose tolerance procedure would be required for only one-third as many (4.3 per cent instead of 12.5 per cent of the total group) if the higher screening level had been used.†

DISCUSSION

The Public Health Service estimates that by 1985 the diabetic population of the United States will show an increase of 75 per cent, whereas the general population will be increased by only 22 per cent.[9] Wilkerson and Krall,[10] as a result of a community survey, suggest that if their findings are projected to the population as a whole, the probability is that there are over two million diabetics in the United States—three undiscovered cases for every four known cases. There has never been any serious doubt raised as to the wisdom of detecting these unknown diabetics as early as possible in the course of the disease. Community programs of diabetes detection are handicapped by lack of adequate standardization of conditions relating to the screening procedure, the proportion of persons screened positive who

†The group requiring glucose tolerance is computed by subtracting the number of previously known diabetes cases from the total of persons screened as positive.

TABLE 2.—AGE, SEX, SCREENING LEVEL AND RESULTS OF GLUCOSE TOLERANCE RE-TEST (SOMOGYI-NELSON) FOLLOWING 100 GRAMS GLUCOSE ON 41 PERSONS OUT OF 305 THAT SCREENED AT 130 MG./100 ML. LEVEL OR HIGHER

No.	Age	Sex	Screening Level mg./100 ml.	Glucose Tolerance Re-test				Point Value
				Fasting	1 Hour	2 Hours	3 Hours	
1	75	F	180	256(4+)[1]	440(4+)	547(4+)	458(4+)	3
2	63	F	180	228(4+)	384(4+)	426(4+)	566(4+)	3
3	37	F	? 180[2]	120(—)	244(2+)	236(4+)	204(4+)	3
4	54	M	180	132(—)	354(4+)	390(4+)	272(4+)	3
5	52	M	180	176(3+)	304(4+)	280(4+)	208(3+)	3
6	39	M	? 180	116(—)	184(—)	164(—)	84(—)	2
7	68	M	130	92(—)	244(2+)	242(4+)	142(4+)	2
8	43	F	130	116(—)	256(4+)	110(3+)	98(—)	1½
9	60	M	130	88(—)	188(2+)	148(2+)	96(—)	1
10	69	F	130	104(1+)	220(—)	120(—)	60(—)	1
11	62	F	130	124(—)	156(—)	64(—)	56(—)	1
12	62	F	130	92(—)	240(tr)	120(2+)	88(—)	1
13	56	F	130	92(—)	176(1+)	142(tr)	84(—)	1
14	47	F	130	96(—)	188(4+)	142(3+)	80(—)	1
15	42	M	130	88(—)	172(—)	104(—)	64(—)	½
16	52	M	? 180	64(—)	172(—)	108(—)	44(—)	½
17	59	M	130	92(—)	252(1+)	104(tr)	88(—)	½
18	35	M	130	100(—)	172(2+)	76(—)	92(—)	½
19	50	M	? 180	60(—)	232(1+)	30(2+)	36(sl tr)	½
20	38	F	130	68(tr)	160(3+)	124(4+)	88(4+	½
21	57	M	130	72(—)	160(—)	120(—)	76(sl tr)	½
22	46	F	? 180	50(—)	X[3](X)	76(2+)	X(X)	0
23	41	F	? 180	78(—)	80(—)	64(—)	22(—)	0
24	63	F	? 180	72(—)	112(—)	80(—)	70(—)	0
25	48	F	130	108(—)	72(—)	70(—)	34(—)	0
26	42	F	130	84(—)	140(tr)	92(tr)	50(—)	0
27	43	F	130	88(—)	122(—)	68(—)	60(—)	0
28	32	F	? 180	80(—)	50(—)	80(—)	64(—)	0
29	53	F	130	60(—)	108(—)	72(—)	50(—)	0
30	33	M	130	84(—)	152(—)	108(sl tr)	88(—)	0
31	49	F	130	64(—)	160(—)	104(—)	56(—)	0
32	60	M	130	98(—)	156(—)	98(—)	84(—)	0
33	47	F	130	96(—)	128(—)	92(—)	72(—)	0
34	57	F	130	72(—)	56(—)	80(—)	50(—)	0
35	63	F	130	72(—)	120(—)	92(—)	84(—)	0
36	53	F	130	88(—)	104(—)	72(—)	64(—)	0
37	39	M	130	52(—)	64(—)	58(—)	44(—)	0
38	58	M	? 180	64(—)	124(—)	76(2+)	56(1+)	0
39*	66	M	180	184(—)	296(3+)	320(4+)	256(4+)	3
40*	62	M	180		Not Done			
41*	57	M	180		Not Done			

[1] Figures in ( ) refer to Benedict's semi-quantitive urine results.
[2] Indicates positive at 130 mg. level and not completely negative at 180 mg.
[3] X=Specimen not obtained.
*Previously known diabetics.

are followed up and the adequacy of the follow-up procedure itself.

Whether or not it is practical to carry out the method outlined in Study D on a wide scale, it should be helpful to explore these problems. Such community studies should have the effect of increasing the local level of medical interest,

TABLE 3.—COMPARISON OF RESULTS OF THOSE RECEIVING BOTH CLINITRON BLOOD TEST AND DREYPAK URINE TEST IN STUDIES B AND C-1955.

Tests	No.	% of Total Tested Both Blood and Urine	New Diabetics No.	% of Group
Positive Dreypak	25	3.4	3	12.0
Positive Blood	31	4.3	2	6.5
Positive Blood-Positive Dreypak	5	0.7	1	20.0
Negative Blood-Positive Dreypak	20	2.7	2	10.0
Positive Blood-Negative Dreypak	26	3.6	1	3.8
Negative Blood-Negative Dreypak	675	93.0	0	0
Total Receiving Both Blood and Urine Tests	726	.....	4	0.6

knowledge and skill in diabetes detection and follow-up. They also allow for a free and frank discussion of chronic disease problems and their solution between practicing physician, clinical laboratory, voluntary and official health agency.

The problem of the proper screening level of blood glucose has been touched upon only slightly in this report. It seems to depend partly on the interest which exists in the medical community for the detection and long term follow-up of the "potential diabetic" group. Long term studies should be made of the group who give glucose tolerance readings coded as greater than zero but less than the diabetic level of two. Unless we know the risk of later development of diabetes in this group, it is tempting to arrange to miss them by screening at higher levels one hour after a challenge dose of 50 grams of glucose, a method which appears to find nearly all of the frank diabetics and avoids the necessity of a large number of extra expensive and fruitless glucose tolerance tests. Perhaps the practice of screening at 160 mg. per 100 ml.‡ represents a good compromise, but the "potential diabetics" found by this procedure should be evaluated by long-term study to be sure.

Additional screening surveys should be performed in special groups as well as in the unselected adult population. Persons with such diabetic predisposing factors as obesity,[11] family history of diabetes,[12] history of having a child of birth weight over 10 pounds,[13] or a record of disturbed glucose metabolism might well be selectively checked periodically by clinitron screening with later glucose tolerance study if needed. Perhaps it may be useful to screen the "potential diabetic" at the 130 mg. per 100 ml. level but from then on to follow him periodically with screening tests employing a higher limit.

Study C did offer some opportunity to compare the Dreypak urine test and the clinitron 130 mg. blood test as a detection device on 814 persons. Table 3 indicates that although the figures are too small to draw detailed conclusions, it does appear that (a) about equal numbers are positive to either test and negative to the other, and (b) some new cases of diabetes can be found in each group. It must be pointed out that the Dreypak test was taken by the patient from any urine specimen he wished and secured many hours or even days after the blood was drawn for the clinitron analysis. Additional studies based upon the method utilized in Study D should employ the urine test on a more rigidly controlled basis and the blood test at a stated time after a challenge glucose dose, if accurate comparisons are to be made.

‡A practical level for clinitron use, since the pipette can be filled with blood to the 0.125 ml. level instead of the usual 0.1 ml. one. Use of this amount of blood with the 180 mg./100 ml. test tablets gives a clinitron reading at the 160 mg./100 ml. level.

SUMMARY

Community diabetes detection programs do reveal a significant number of previously unknown diabetics. The yield can be increased up to ten times when all those screening positive are followed-up with at least a three hour glucose tolerance test. The screening procedure can be adjusted to detect or miss the "potential diabetic" group with little or no effect on the number of previously unknown diabetics found.

Long term studies are currently being conducted to determine the value of screening to detect the "potential diabetic" or those who give slightly abnormal patterns in the glucose tolerance test.

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Information and Misinformation Gained from Fasting Blood Sugar Alone in Diabetes Therapy

HENRY J. JOHN, M.D.

FOR many years my routine checkup of diabetic patients has been to do blood sugar determinations before breakfast, lunch and dinner at roughly 8:00 and 11:00 a. m. and 3:00 p. m., or fasting, three hours after breakfast and three hours after lunch. We know that in a nondiabetic the blood sugars taken at such time are normal, that in the three hours after a meal the blood stream has cleared itself of the excess of sugar. We also know that a diabetic on diet and proper insulin dosage also will show normal levels in all 3 blood sugars, or that at least 2 of the 3 blood sugars will be normal. We try to find out in this manner for how many of the 24 hours a diabetic patient is normoglycemic and for how many he is hyperglycemic and to what degree.

Even a nondiabetic patient will show a relatively mild hyperglycemia after each meal, but the blood sugar comes down to normal within 1.5 to 2 hours. This is normal physiology. Thus, if we take the maximum time of postprandial hyperglycemia in a nondiabetic, namely 2 hours times 3 (three meals), we will get hyperglycemia up to 6 hours out of every 24 or 25 per cent of the time.

Using this as our normal standard comparison, we are on the right track in control of the diabetic if we can limit his hyperglycemia to 25 or 30 per cent. If it is 50 per cent or more, then we must change his routine, either try reducing his diet or increasing the insulin or both. This is the basis of evaluation of a diabetic control. We can, in addition, estimate the number of grams of sugar in the 24 hour urine specimen or just perform urine sugar simultaneously with the blood sugars examinations.

The usual method is to examine the morning urine specimen for sugar and to do an occasional fasting blood sugar, basing the dosage of insulin on this evidence. In this article I want to show how inadequate such a procedure is, that the fasting blood sugar alone may lead to misinformation rather than to information and that only when we take the preprandial blood sugars, do we gain adequate information about the patient's progress or lack of progress and definite information as to the insulin dosage.

In table 1 one can readily see the lack of correlation between the blood sugar and the urine sugar which is well known. On the first examination, Sept., 1940, the 11:00 a. m. blood sugar was 405 mg. per 100 ml. and the urine showed only a trace of sugar. In Jan., 1941, the fasting blood sugar in the same patient was 104 mg. per 100 ml. and the urine showed 1 plus sugar. In March, 1946, the fasting blood sugar was 180 mg. and there was no glycosuria, etc. Many similar discrepancies could be described, not as exceptional, (as often is done) but as everyday findings. I feel that no one can properly guide a diabetic patient's dosage of insulin by urine examinations alone, nor can this be done by the taking of an occasional fasting blood sugar, or a single, occasional blood sugar done at any time of the day.

The following summaries illustrate my point. The accompanying charts (Charts I-a, and I-b; II-a and II-b) show the regular three-a-day blood sugar levels in contrast in the b charts using the fasting blood sugars alone in the same patient.

Case 1. The patient was a female, 56 years old. She stated that sugar had been found in the urine the year before (1930). She had gone on a diet, could not become sugar free. Then she took some "Sani-tablets." There was no history of diabetes in the family. She was somewhat obese. Her original blood sugar in my office was 171 mg. per 100 ml., two hours after meal and she showed heavy glycosuria. She was put on insulin for over two months. The blood sugar came down, insulin was discontinued for three years, and she managed fairly well. Insulin was resumed in 1935 and beginning 1937 had to be steadily increased, up to 85 units a day, because

TABLE 1.—SHOWS LACK OF CORRELATION BETWEEN BLOOD SUGAR AND URINE SUGAR

Date		8 a. m.	11 a. m.	3 p. m.	
9-14-'40	Blood sugar	400	405	319	First seen by me.
	Urine sugar	+	tr	+	Ins. started
1-31-'41	Blood Sugar	104	197	142	
	Urine sugar	+	+	+	
	PZI	25			
7-17-'45	Blood sugar	71	280	500	
	Urine sugar	tr	tr	++	
	PZI	21			
	Insulin	41			
3- 6-'46	Blood sugar	180	250	260	
	Urine sugar	0	tr	tr	
	PZI	30			
	Insulin	35			

Urine sugar: 0—none; green—trace; yellow—1 plus; Brick red—++.

Submitted July 22, 1957.

The Author

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of the wide fluctuations of the blood sugars. She died in 1947 of coronary occlusion at the age of 72, having had diabetes 17 years.

Chart I-a, shows the progression of diabetes in this case according to determinations of blood sugar made three times daily. Chart I-b, shows only the fasting blood sugar data which would indicate that all was well throughout the 16 years of observation. There are only three rises

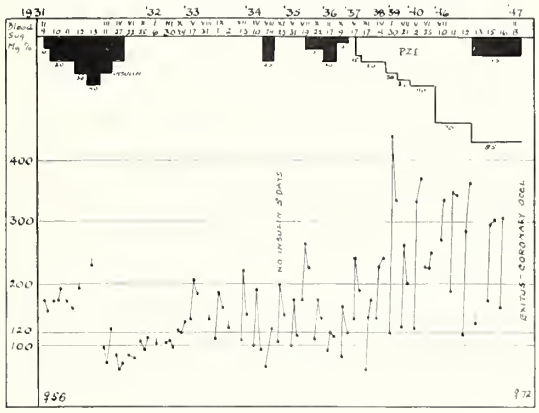


Chart I-a

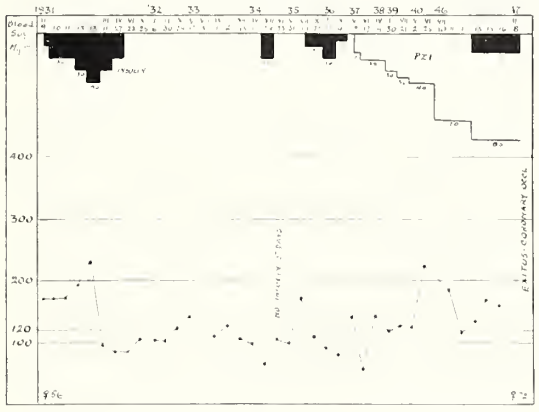


Chart I-b

in the fasting blood sugar; the rest are quite normal. One can never make enough studies of the blood sugar level throughout the day in order to get a clear picture of the progress of the patient and his changing needs for insulin. Had we had only the fasting blood sugars from 1938 on, the increased need for PZI (protamine zinc insulin) would not have been known, whereas Chart I-a, indicates this need distinctly.

Case 2 (Chart II-a) was a patient 26 years old, a housewife. She stated that diabetes had been discovered six months previously (Oct., 1930). At that time she had the classical symptoms of diabetes. She had dieted and had been taking some "Insulin pills" by mouth. She improved somewhat the first two months and then she went on a normal diet and her condition retrogressed. A year ago she had weighed 123 pounds, which was normal for her height. Now she weighs 105 pounds. There is no diabetic history in the family. She had shortness of breath on exertion, her endurance was poor, her menses regular. She had been married two years with no pregnancies. Blood pressure was 130/68. She showed an adenoma of the thyroid with hyperthyroidism, the basal metabolic rate + 57 per cent.

Since her blood sugar was normal on entrance, a glucose tolerance test was done the next day which showed a diabetic curve. She was placed on a 2,500 calorie diet and no insulin. The fasting blood sugar remained normal with one exception.

On the day of her thyroidectomy the noon blood sugar was somewhat elevated and the evening blood sugar slightly, but from there on the fasting blood sugars remained normal. It was felt that there was a slight disturbance of the carbohydrate metabolism which, after the operation would more than likely straighten out. Before she was discharged from the hospital I repeated the G. T.-2 which still showed a diabetic curve. Subsequent blood sugar checks were normal. In December 1931, seven months after her thyroidectomy, a third glucose tolerance test showed a slight improvement but still was not normal.

Then I heard nothing from her for two years when she had given birth to a premature baby, 6.5 months. It was on March 30, 1936, i. e. five years after thyroidectomy and three years after parturition that I saw her again. At this time she had frank diabetes and was taking 50 units of insulin a day. Following this, on diet and insulin, she showed a considerable fluctuation of the blood sugar, more than was desirable, in spite of the large dosage of insulin, up to 75 units a day. The fasting blood sugar most of this time normal, but the noon and the evening blood sugars were elevated as can be seen on Chart II-a for a period of 15 years.

The impact of hyperthyroidism on a slight disturbance of the carbohydrate metabolism, and the second impact of pregnancy, probably with

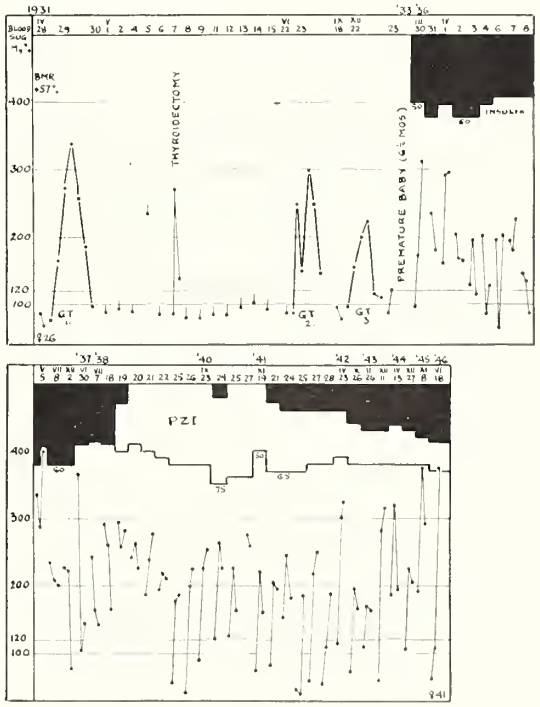


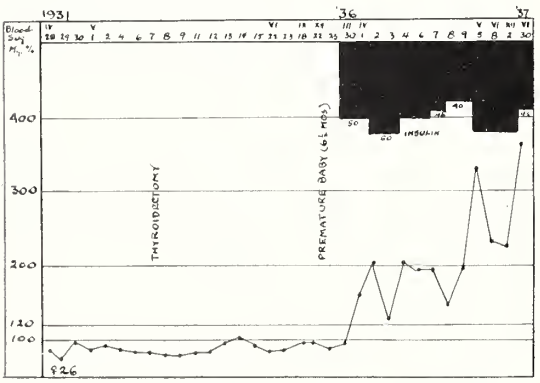
Chart II-a

a poor or no control at that time, was enough to elicit frank diabetes. Thus one cannot afford to disregard the early and mild signs of the upset of the carbohydrate metabolism as they frequently lead to a more serious condition as this and the preceding case show.

Were we to have merely the data of the fasting blood sugars which are presented in Chart II-b, we would have missed completely the preliminary tell-tale information during the stage of hyperthyroidism. The first inkling we would have of diabetes would have been in March, 1936, i. e five years later, when a frank diabetic state existed. And, from the latter part of 1938, one would feel that all had been accomplished that could be accomplished from the fasting blood sugar figures alone. Only from Chart II-a do we get a clear picture of the true state of affairs. Again one must say that one cannot have too much laboratory information on a patient, that it is the more complete workup which gives a clearer and accurate picture.

I add here an interesting study to demonstrate how misleading the occasional or random blood sugar determination can be, as well as the fasting blood sugar alone.

This was a classical experiment that I did over 30 years ago[2] which is illustrated in Charts III-a, b, c. At the top is represented the diet the patient was on—black being the carbohydrate, the shaded portion the protein, the clear part the fat.



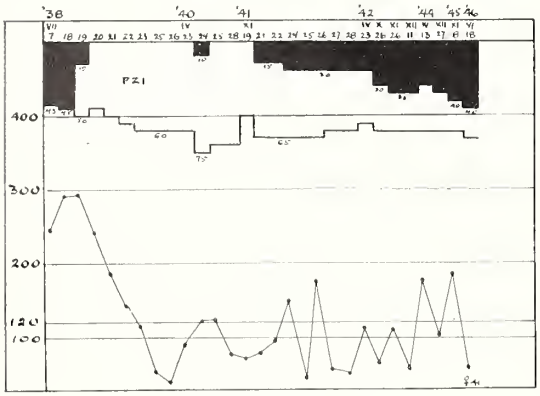


Chart II-b

Case 3. The patient was a little girl some 8 years old. For 15 days the patient was on 100 Gm. carbohydrate, 60 Gm. protein, 128 Gm. fat, a total of 1,800 calories and taking 10 units of insulin which was changed after nine days to 20-0-10 units and kept at that point with the exception of only one day throughout the experiment. After the preliminary 15 days, the diet was practically doubled, 150 Gm. carbohydrate, 100 Gm. protein, 220 Gm. fat, a total of 2,980 calories; and from November 5 to 8 the diet was reduced to 80 Gm. carbohydrate, 50 Gm. protein, 130 Gm. fat, a total of 1,700 calories.

In Chart III-a, I have shown graphically the daily blood sugars, three times daily, before meals, made in a mild case of diabetes while the patient was in the hospital. The insulin dosage is indicated in the upright columns at the bottom.

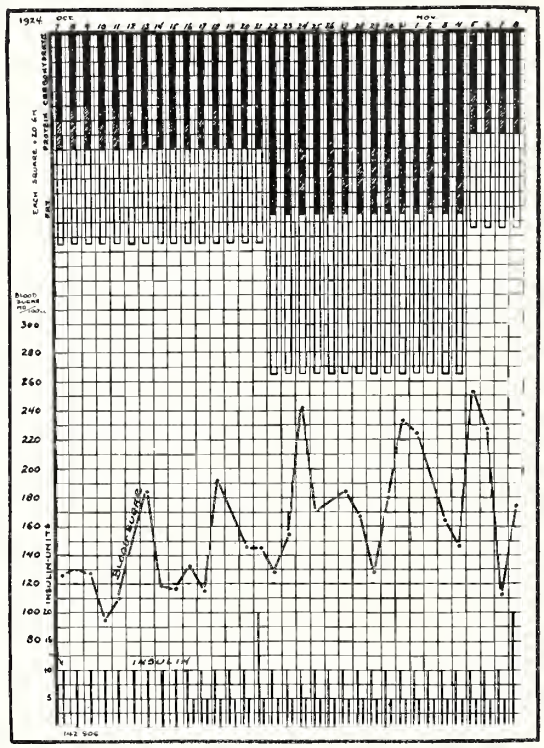


Chart III-a

In Chart III-a, appear all the data regarding the diabetic status of the patient. This Chart shows that there was a considerable fluctuation in the blood sugar from day to day on the first dietary routine of 1,800 calories, the fluctuation being increased when the diet was increased (practically doubled) and lessened again when the diet was reduced at the end.

Chart III-b is made up from Chart III-a, where only an occasional blood sugar was selected from this same patient on different days. This Chart would give a very definite impression that while the patient was, at the beginning on the low caloric diet, the blood sugars were normal, for the Chart does not show the actual fluctua-

tions during this period. During the second period, on increased diet, this Chart would make it appear that there was a sustained rise in the blood sugar as the diet was increased and again a distinct fall of blood sugar to normal level as the diet was decreased.

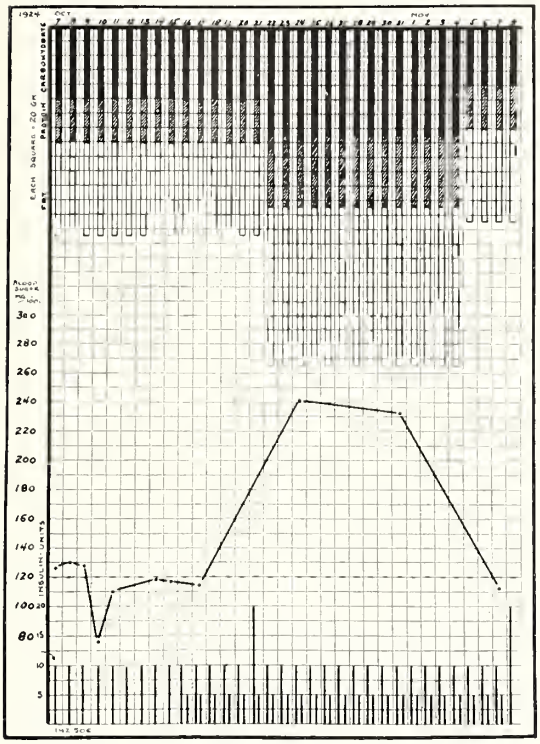


Chart III-b

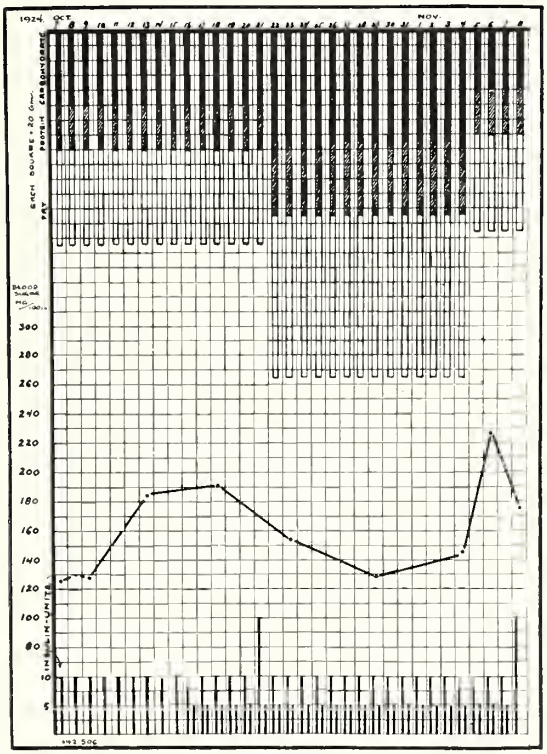


Chart III-c

For Chart III-c, certain of the blood sugars in this case of this same patient, taken from Chart III-a, were purposely selected in order to illustrate the point I am emphasizing. These figures would make it appear that while the patient was on the low caloric diet, the blood sugars were apparently increased. When the diet was increased, the blood sugar was apparently decreased, and when the diet was again decreased, the blood sugar was apparently increased. If the physician had only the data from these isolated estimations, Charts III-b, c, as might very easily happen if the blood sugars were taken at indefinite intervals (which frequently does take place), how great would be the misconception of the real state of the patient!

These Charts emphasize the necessity of making a sufficient number of blood sugar estimations while the patient is in the hospital or in the physician's care, for him to have definite information on which to base his judgment both regarding the treatment of the patient while he is under observation and also after he returns to his home.

Charts III-a, b, c, illustrate my point clearly, I think, namely that the taking of only an occasional blood sugar may lead to misinformation as demonstrated in these Charts, especially Chart III-c.

SUMMARY

Graphic Charts on three diabetic patients are presented, illustrating periodic checkups, three times daily, before meals, each time over a long period of time. Against this information, a Chart reconstructed on the same patient, in which only the fasting blood sugars are given, which is the usual practice at large. These Charts illustrate the discrepancies on the two categories of information and show how one can be misled if only the fasting blood sugar is done and no attention paid as to what happens the rest of the day. It is evident from these Charts that one cannot have too much laboratory information on a patient, or, to put it in other words, that the lack of adequate information leads often to misconception of the real status of the patient's diabetic state, namely his proper control on any given routine.

In the last three Charts, I recapitulated what I wrote over 30 years ago,[3] namely, that the taking of only an occasional blood sugar may lead to a gross misconception of the patient's real status.

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Management of Diabetes with Tolbutamide (Orinase®)

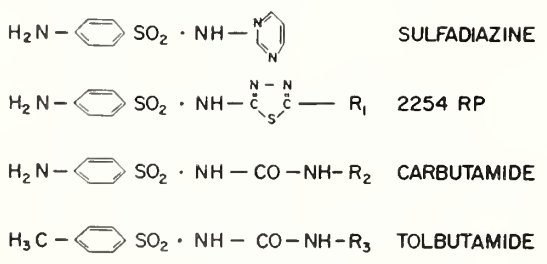
RICHARD L. FULTON, M.D., and GEORGE E. BELL, M.D.

ONE of the greatest medical advances of this century has been the discovery of insulin by Banting and Best in 1921. The obvious objections to the parenteral administration of insulin have served as stimuli to encourage numerous investigators to search for oral preparations that could be used in the treatment of diabetes mellitus.[1,2,3,4] Guanidine and synthaline were among the first substances investigated. They did produce hypoglycemia but were discarded because of their toxicity. Later it was noted that numerous sulfonamide preparations possessed the ability to produce hypoglycemia.

Janbon in 1942 investigated a compound (2254 RP) for its bacterial action in typhoid fever. He noted peculiar reactions in these animals and it was later proved by Loubatieres that these reactions were due to hypoglycemia. Another sulfonamide (carbutamide—BZ 55) was extensively investigated and was found to produce hypoglycemia. Bertram reported on this product of the Boehringer Company at the 18th Congress of Digestive and Metabolic Diseases in Germany in October 1955. This compound also received considerable attention in the Canadian literature, but was withdrawn from investigation in the Fall of 1956 because of its toxicity.

CHEMISTRY OF TOLBUTAMIDE (ORINASE, D 860, U 2043)

Tolbutamide is the most recent hypoglycemic agent under investigation. This compound differs from the other sulfonamide preparations studied in that it is not bacteriostatic, the difference chemically being the presence of a methyl group rather than an amino group as shown by the following chemical formulas.



It has been established that the sulfonamide group itself is indispensable for the hypoglycemic action and that this action also depends upon the substituent R group (butyl in the case of tolbutamide). Tolbutamide is not stored in the body and is found in the greatest concentration in the blood, urine and bile.

Submitted April 8, 1957.

The Authors

● Dr. Fulton, Columbus, is assistant professor of clinical medicine, Ohio State University; associate director, The Columbus Medical Center; on staffs of University, Mount Carmel, Grant, White Cross, and St. Anthony Hospitals.

● Dr. Bell, Columbus, is instructor, clinical medicine, Ohio State University; staff physician, The Columbus Medical Center; on staffs of University, Mount Carmel, Grant, White Cross, and St. Anthony Hospitals.

MODE OF ACTION OF TOLBUTAMIDE

The exact mode of action of tolbutamide is still unknown. It is known that tolbutamide is rapidly absorbed from the gastrointestinal system. In spite of this rapid absorption, the peak action and duration of action vary considerably from patient to patient and are not nearly as constant and predictable as with insulin preparations. In most patients, tolbutamide, by the oral route, produces a definite lowering of the blood sugar within one or two hours, reaches its peak action in six to nine hours and continues to act for approximately 24 hours; however, hypoglycemia has been noted for a much longer period of time than this in individuals receiving a single dose of tolbutamide. It is for this reason that a single daily dose of tolbutamide is just as effective as multiple daily doses.

Tolbutamide does not produce hypoglycemia in the absence of a functioning pancreas and is ineffective in alloxan-diabetic animals. The adrenopituitary axis is not linked with the antidiabetic effect of tolbutamide and there has been no demonstrable change in the corticoid excretion in the urines of individuals so treated. It seems to have no definite effect on the liver as evidenced by liver function tests, but it has been noted that toxic levels of this drug cause a reduction in the amount of hepatic glycogen and also decrease the mobilization of liver glycogen by injected Adrenalin® and glucagon.

Microscopic study of the pancreas in rabbits and human beings has demonstrated no alteration of the alpha cells but it has been noted that the beta cells may be reduced and that this may suggest a functional rest. Tolbutamide apparently has no effect on the thyroid gland, the

blood elements, the kidneys, nor the cardiovascular system.

At present it would seem that these agents do not inhibit the action of glucagon secretion, do not act through any suppressive action on the adrenal nor hypophysis nor do they appear to have a true insulin-like action as demonstrated by the inability of tolbutamide to increase the glucose uptake of muscle in vitro experiments. It is quite possible that tolbutamide exerts its effects by altering certain liver enzyme systems which operate upon the transformation of non-glucose precursors to glucose. Other possible actions are the inhibition of insulinase or the stimulation of the beta cells of the pancreas to a greater production of insulin.

METHOD OF STUDY

The charts of 100 diabetic patients were analyzed. It was felt that 12 of these patients fulfilled our criteria for clinical investigation as listed below. Other patients qualified medically as potential candidates for tolbutamide therapy but were not included in the original study if, for some reason or another, they were unable to cooperate completely with the proposed plan of investigation. The following criteria were satisfied before a patient was started on this investigative procedure:

(1) All patients studied were adults with diabetes which could easily be controlled with insulin not exceeding 20 units daily.

(2) All patients required more than diet alone to control their diabetes.

(3) No patient was treated who presented diabetic complications which required specific therapy for the complication itself.

The 12 patients selected for study were carefully instructed regarding all phases of the investigation. Their ages ranged from 29 to 73 years. The duration of existing diabetes ranged from 1 to 20 years. Only three of the 12 patients studied were overweight. They had all previously been maintained on from 12 to 22 units of NPH insulin daily. None of the patients had any diabetic symptoms at the time of the beginning of this investigation.

While on insulin and prior to tolbutamide therapy, nine of the 12 patients were considered well controlled. The other three patients were poorly controlled, not because of the severity of their diabetes, but because of their lack of understanding and cooperation.

Before the actual study was begun, all patients submitted a record of their urines tested four times daily for a period of a week. The tolbutamide test was then performed on 11 of the 12 patients in the following manner: They were instructed to come to the office in a fasting state without having taken their usual dose of insulin. A fasting blood sugar was obtained and the patient was then given 3 grams of tolbutamide by mouth. The blood sugar was repeated four hours later and the patient was considered sufficiently reactive to tolbutamide to justify a therapeutic trial with this drug if there were a fall of 30 per cent between the two blood sugars obtained.

At this test, the patients were told to discontinue their insulin for a period of one week. It was felt that we should determine whether these patients really did need insulin for control of their diabetes. Since many diabetics are well controlled on diet alone, we did not want to give false credit to tolbutamide for good diabetic control when possibly such could have been maintained just as well by diet alone. Our patients were carefully instructed to check their urines four times a day and to report immediately if the urines became positive for sugar or if any symptoms developed.

After this week of trial without insulin, the patients were then placed on 1 to 2 grams of tolbutamide daily and all other diabetic measures maintained as before. Urines were again carefully checked by the patient before each meal and at bedtime and a record of these results was submitted during the patient's weekly visit to the office. Patients were also interviewed as to the development of symptoms and their general sense of well-being during tolbutamide therapy.

CASE REPORTS

Following are brief case reports of the 12 patients initially studied. Each patient has been under observation for approximately a six months' period of time:

Case No. 1—71 year old white male with diabetes of four years' duration. He was well controlled on 15 units of NPH insulin daily. His tolbutamide test revealed a fasting blood sugar of 130 mg. per 100 ml. The blood sugar fell to 63 mg. per 100 ml. in four hours. Patient is now well maintained on 1 gram of tolbutamide twice a day.

Case No. 2—36 year old white male with diabetes of one year's duration who was well controlled on 20 units of globin insulin. The tolbutamide test revealed a fasting sugar of 243 mg. per 100 ml. His blood sugar fell to 154 mg. after four hours. However, his diabetic control on tolbutamide was very poor. He lost 6 pounds during a nine day period of observation and his urines became strongly positive for sugar. This occurred in spite of 2 grams of tolbutamide daily. This patient was put back on insulin and good control again achieved.

Case No. 3—29 year old white male with diabetes of one year's duration who was well controlled on 15 units of NPH insulin daily. The tolbutamide test revealed a fasting blood sugar of 196 mg. per 100 ml. and his blood sugar fell to 168 mg. per 100 ml. Maintenance on 1.5 grams of tolbutamide daily in the morning was attempted, but the patient developed symptoms of uncontrolled diabetes and had to be put back on insulin. At present, this patient is well controlled on 20 units of NPH insulin daily.

Case No. 4—58 year old white female with diabetes of seven years' duration who was well main-

tained on 22 units of NPH insulin daily. The tolbutamide test was not performed on this patient. At the present time, she is maintained on 1.5 grams of tolbutamide in the morning and ½ gram in the evening. Her control has remained very good in spite of the fact that she is also receiving 5 mg. of prednisone twice a day as treatment for her arthritis.

Case No. 5—51 year old white male with diabetes of four years' duration who was well controlled on 15 units of NPH insulin daily. During the tolbutamide test, his fasting blood sugar was 192 mg. per 100 ml. and this fell to 146 mg. after four hours. Excellent control of his diabetes was obtained with 1 gram of tolbutamide daily in the morning. This dosage was subsequently reduced to ½ gram of tolbutamide daily. His control remains excellent on this reduced dosage.

Case No. 6—60 year old white female with diabetes of 20 years' duration who was well maintained on 15 units of protamine zinc insulin. During the tolbutamide test, her fasting blood sugar was 116 mg. per 100 ml. and this fell to 93 mg. Her diabetes is well controlled on 1.5 grams of tolbutamide in the morning.

Case No. 7—73 year old white male with diabetes of two years' duration who was well controlled on 15 units of NPH insulin daily. His fasting blood sugar was 169 mg. per 100 ml. The blood sugar fell to 96 mg. during the tolbutamide test. In spite of good control of his diabetes, this patient developed abdominal cramps and "felt horrible." He demanded that he be put back on insulin. This was done and his symptoms all disappeared in several days.

Case No. 8—63 year old white female with diabetes of four years' duration who was well maintained on 10 to 15 units of NPH insulin daily. Her fasting blood sugar was 165 mg. per 100 ml. and her blood sugar fell to 83 mg. during the tolbutamide test. The patient was well maintained on 1 gram of tolbutamide daily. After approximately five months' therapy with this dose, the patient developed definite symptoms of hypoglycemia.

At that time, a blood sugar was obtained one hour after the patient had ingested a large amount of carbohydrate at home prior to coming to the office (she administered this carbohydrate on her own because she stated that her symptoms were exactly like those previously experienced when she was taking too much insulin). This blood sugar was only 111 mg. per 100 ml. in spite of the large amount of carbohydrate previously consumed. It is felt that her blood sugar was much lower than this when she frantically called on the telephone reporting her symptoms. This patient is now very well maintained on ½ gram of tolbutamide daily.

Case No. 9—72 year old white female with diabetes of two years' duration who was fairly well maintained on 15 units of NPH insulin daily. Her fasting blood sugar was 247 mg. per 100 ml. and the blood sugar fell to 169 mg. per 100 ml. during the tolbutamide test. She maintained excellent control on 1½ grams of tolbutamide daily. After one week of therapy, she fractured her hip. Good diabetic control was maintained with tolbutamide in spite of this traumatic accident.

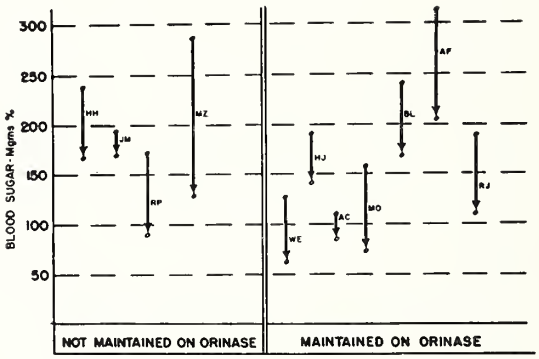
Case No. 10—59 year old white female with diabetes of 16 years' duration. She had been well controlled previously on 20 units of NPH insulin but had refused to take insulin for some months prior to this investigation. She spilled sugar in the urine to excess and her fasting blood sugar was 323 mg. per 100 ml. This fell to 201 mg. during the tolbutamide test. On 1 gram of tolbutamide daily in the morning, excellent diabetic control is maintained and she feels much better than she did even while taking 20 units of insulin.

Case No. 11—56 year old white male with diabetes of 12 years' duration who was poorly controlled on 20 units of NPH insulin daily because of his refusal to limit his caloric intake. His fasting blood sugar was 285 mg. per 100 ml. and this fell to 130 mg. during tolbutamide test. His diabetes was better controlled during the tolbutamide period, but he developed an exacerbation of his arthritis and desired to go back on insulin. The re-administration of insulin did not affect his arthritis at all and it is felt that the recurrence of the arthritis was unrelated to the administration of tolbutamide.

Case No. 12—63 year old white male with diabetes of five years' duration who was well controlled on 20 units of NPH insulin daily. During the tolbutamide test, his fasting blood sugar was 192 mg. per 100 ml. and his four hour blood sugar was 110 mg. per 100 ml. He is well maintained on 1½ grams of tolbutamide daily and feels just as well as when he was on insulin.

DISCUSSION OF RESULTS

There did not seem to be much correlation between the response of the patients to the preliminary tolbutamide test and their eventual maintenance on tolbutamide therapy. (See chart)



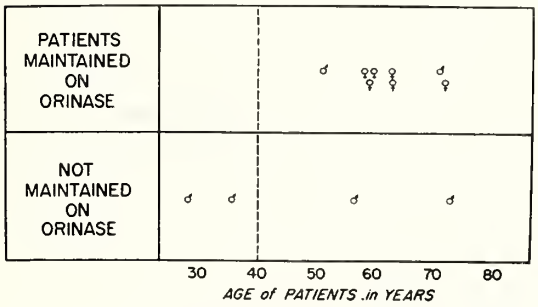
CORRELATION of ORINASE TEST and MAINTENANCE THERAPY

Nine of the 11 patients on whom the tolbutamide test was performed had at least a 30 per cent drop in their blood sugars. Of these nine cases with a "positive response" it was possible to maintain six of them on tolbutamide therapy. The other three patients, in spite of a "positive" tolbutamide test, had to be put back on insulin. Of the two cases giving a negative response during the tolbutamide test, it was possible to maintain one of them (Case No. 5—fall in blood sugars of 20 per cent) on tolbutamide but the other patient (Case No. 3—fall in blood sugars of 14 per cent) had to be put back on insulin. The average percentage decrease of blood sugars during the tolbutamide test in those eventually maintained on tolbutamide was 33 per cent, whereas the percentage decrease in blood sugars of those

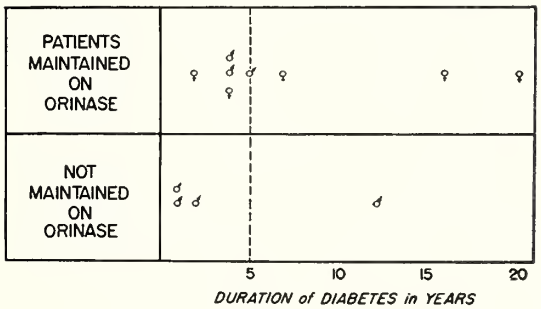
individuals unable to be maintained on tolbutamide was 35 per cent.

All 12 patients during the period of time in which insulin was discontinued developed symptoms of diabetes or experienced an increased amount of glycosuria.

Eight of the 12 patients initially studied have been maintained satisfactorily on tolbutamide for a period of six months. This percentage agrees with statistics reported to date.[5]



All of our patients were over 40 years of age except two and both of these had to be put back on insulin because tolbutamide did not control their diabetes. (See chart) In a report by German investigators[6] 23 of 83 patients under 40 years of age were satisfactorily controlled.



It is interesting that five of our 12 patients had diabetes for five years or longer and that insulin had been necessary to control their diabetes prior to the institution of tolbutamide therapy. Four of these five patients have been well maintained on tolbutamide. (See chart)

Although it has been recommended from other studies that the ideal patient for tolbutamide maintenance therapy is an obese diabetic, nine of our 12 patients were of normal weight. Of these nine patients, six were well maintained on tolbutamide.

None of the patients studied developed any skin rashes, leukopenia, nor signs of renal failure. Such were carefully watched for by frequent examinations, blood counts before and during maintenance therapy and repeated renal function tests. The symptoms of patient—Case No. 7, probably represented an idiosyncrasy to tolbutamide rather than a toxic reaction. He did not develop any of the occasionally observed and reported complications. Such have occurred rarely as reported by The Upjohn Company in its fourth "Orinase® Progress Report." There were only 47 instances of side reactions in 2,052 cases reported. These consisted of 21 dermatological and one hematological complications. The other 25 were less specific such as nausea, epigastric fullness, diarrhea, etc.

CONCLUSIONS

The small number of patients studied does not permit any statistical conclusions; however, certain impressions were established and these are as follow:

(1) There is no definite correlation between the response of a patient to the tolbutamide test and the possibility of his being maintained on tolbutamide therapy.

(2) Tolbutamide does control a significant number of diabetic patients.

(3) Tolbutamide maintenance therapy is more probable in the older age group of diabetics.

(4) The duration of existing diabetes does not seem to be a definite factor as to whether an individual can or cannot be maintained on tolbutamide. No single individual should be denied a therapeutic trial with tolbutamide simply because he has had diabetes for a long period of time.

(5) Normal weight in itself is not a contraindicating factor for a therapeutic trial with tolbutamide.

(6) One of the patients probably developed his symptoms because of an idiosyncrasy to tolbutamide.

(7) No toxic reactions occurred in any of the 12 patients studied.

(8) It would probably be worth while to offer a trial of therapy with tolbutamide to every adult diabetic. We have already adopted this policy with our diabetic patients.

ADDENDUM

Since submission of this article, six additional diabetic patients have been started on tolbutamide therapy. Their previous insulin requirements varied from 15 to 22 units. All have maintained excellent control of their diabetes by clinical and laboratory standards. None have experienced any toxic reactions.

Acknowledgment: We wish to thank The Upjohn Company for providing the Orinase used in this study and for subsequent maintenance therapy.

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Diabetes Insipidus Associated with Schizophrenia: Remission Following Electroshock Therapy (Report of a Case)

BEATRICE POSTLE, M. D.

THE following case led to some speculations on the significance of the symptoms of diabetes insipidus in an adolescent girl presenting a schizophrenic-like syndrome; of the application of some of the theories elaborated by Gellhorn[1] in regard to the probability of disturbed hypothalamic function and lowered sympathetic reactivity in the psychoses, and the possible mode of action whereby electroshock therapy produces improvement in such cases.

CASE REPORT

An adolescent female was admitted to Athens State Hospital July 16, 1956, at age 14. The family history indicates that a grandfather suffers from diabetes mellitus and that two first cousins have been patients in mental hospitals. The patient was born March 12, 1942. Her birth and early development were normal. She had only the usual diseases of childhood. Polyuria began in the pre-adolescent period. She was shy and retiring, never a problem child in any way; she was an excellent student and was two years in advance of her age group at school. She continued in school until June 1956, but for a year or two previously had been worrying about her frequent urination and had been eating improperly.

By the time of her admission to the hospital her weight had dropped from 110 pounds to 68 pounds. She seemed depressed, had crying spells, and made suicidal threats. She was excessively suspicious at times. At the time of her admission she was found to be poorly nourished; height 5 feet 4½ inches; weight 68 pounds. The heart was small; the blood pressure 80/60; pulse 48. Her hands and feet were cold and cyanotic. There was no breast development; the uterus was apparently infantile, and she had never menstruated; there was obstinate constipation.

She passed large quantities of urine (4000 to 7000 cc. per day); there were no abnormal constituents of the urine; the specific gravity ranged from 1.003 to 1.006. The glucose tolerance test showed a flat curve, the blood sugar reaching a maximum of 100 mg. in two hours; the lowest value was 60 mg. An x-ray of the skull showed a closed type of sella with a marked possibility of some calcification of the pituitary. Basal metabolism and Funkenstein tests were not done.

The patient answered questions in a minimum of words, spoke in a weak, slow voice as if with effort. Her facial expression was vague and dreamy with an occasional inappropriate smile. Her emotional reactions were flat. She stood around in the halls, was seclusive, and had little to say to anyone. She was started on Pitressin® and this controlled the polyuria fairly well but not entirely.

By the time she had been in the hospital 25 days she was eating so poorly that it was decided that she should be given electroshock therapy. Eleven electroconvulsive treatments were administered between August 10, and September 7, 1956. From the time of the first treatment she started to improve and at the time she left here on September 21, 1956, she had gained 27 pounds, was eating well, was almost free from the symptom of polyuria, and was much different mentally. She became alert, friendly, sociable, interested in her personal appearance, and in things around her.

The last report I had concerning her was in January 1957, at which time her mother wrote that the patient still had some trouble with frequent urination but was getting along well in other respects. She enclosed a newspaper clipping which indicated that her daughter is an honor student in high school.

Submitted May 7, 1957.

The Author

● Dr. Postle, Athens, is a member of the staff at Athens State Hospital.

DIABETES INSIPIDUS AND POLYURIA IN SCHIZOPHRENIA

Although my search in the Index Medicus was by no means exhaustive, I did not find any reference to the subject of diabetes insipidus in schizophrenia. In the literature on diabetes insipidus, however, there were not infrequent references to concomitant symptoms of disturbed mental functioning and "nervousness." In 1954, Bauer[2] reported a survey of 60 cases with autopsies of persons having hypothalamic disease. The most frequent symptom (43 of 60 cases) was the presence of sexual abnormalities, precocious puberty or hypogonadism.

Next in frequency were found, in an equal number of cases (one-third), diabetes insipidus and psychic disturbances. Other symptoms found in a lesser number of cases were: Somnolence, obesity, emaciation, thermodysregulation, autonomic crises, bulimia, and anorexia. Hypogenitalism was frequently associated with diabetes insipidus. The extent of destruction of the hypothalamus did not necessarily correspond to the degree of alteration in vegetative function.

There have not been reported many quantitative urine studies in schizophrenia. There are some, however, Bleuler,[3] in his textbook, states: "In the chronic states, the quantity of urine excreted seems to be in normal proportion to the amount of food and liquids ingested. In activations of the

illness there may be marked irregularity, from excretion of large amounts of urine to oliguria." Hoskins[4] reports that a study at the Worcester State Hospital revealed that the urine output in a group of schizophrenics was nearly twice that of control subjects living in the same environment and eating the same food. In one book of Kraepelin[5] this statement appears: "Now and then diabetes insipidus is observed."

In the past year there came to my attention two other cases of patients presenting symptoms of marked polyuria. Both were schizophrenic males who had been mentally ill for several years. In one, the polyuria came on suddenly during a course of Thorazine® therapy. He also had convulsions for the first time. After medication was discontinued, symptoms disappeared in a few days. The other patient developed symptoms of extreme polyuria during electroshock therapy and his symptoms disappeared within a few weeks.

HYPOTHALAMIC DISTURBANCE IN THE PSYCHOSES

I do not know who first suggested that the hypothalamus may be implicated in mental illness, but more than 40 years ago Kraepelin[5] discussed Meynert's theory of "periodic disturbances of vasomotor innervation."

In their textbook published in 1920, Tilney and Riley[6] state that diencephalic disturbances undoubtedly underlie the production of that extensive group of nervous maladies known as the neuroses and the psychoses.

Foster Kennedy, Roy Grinker, Bernard Alpers, Ernst Gellhorn, H. Douglas Singer, Ranson and Nielsen are among those who have written about the probability of many of the so-called functional mental diseases being associated with disturbances of autonomic centers and the possibility of these disturbances playing a central role in the etiology.

It has been established that the controlling mechanisms of autonomic function are located in the hypothalamus. The following is quoted from Ingram[7]: "It undoubtedly contains integrative mechanisms which, in addition to their effect on behavior patterns, also aid in regulating the basic life functions of the organism. However, this integration is apparently carried out through its relationships with other parts of the nervous system, including the so-called higher levels as well as through the endocrine system. It must be appreciated that while this interesting region of the brain is only part of a system of complex circuits, it is a very important link in these circuits, and is so strategically placed that its derangements may have profound effects."

ETIOLOGY OF DIABETES INSIPIDUS

It has been known for some time that the absence of the antidiuretic hormone leads to the clinical picture of diabetes insipidus. Recent theories have evidence to support the view that the supra-optic nuclei of the hypothalamus and the supra-opticohypophysial tract are involved as well as the posterior pituitary.

GELLHORN'S THEORIES REGARDING THE NEUROPHYSIOLOGICAL CONCOMITANTS OF SCHIZOPHRENIA

Gellhorn,[1] whose book *Physiological Foundations of Neurology and Psychiatry* is well known, has come to the conclusion that "schizophrenia is physiologically characterized by a deficient reaction of the sympathetic division of the autonomic nervous system at the hypothalamic level, possibly initiated by over-activity and favored by constitutional factors. The weakened sympathetic and somatic 'downward discharge' is expressed in a decreased blood pressure and lessened circulatory adjustment reactions, and also a diminished muscle tone, whereas the failure of the hypothalamus to regulate hypophysial secretions leads to endocrine disturbances.

"The reduced reactivity of the hypothalamus to cortical stimuli further contributes to defects in homeostasis. The mental changes attending schizophrenia are primarily related to a defective hypothalamic-cortical discharge." He believes, and offers clinical and investigative evidence, that electroshock produces its beneficial results by stimulating the hypothalamic autonomic centers, thereby producing intensive and prolonged sympathetico-adrenal discharges, and a l t e r i n g, through augumented hypothalamic-cortical activity, mental processes and behavior. There are upward (to the cortex) discharges from the hypothalamus as well as downward.

APPLICATION TO THIS CASE

These theories of Gellhorn appear to be particularly applicable to the case reported in this paper. In addition to the symptoms of diabetes insipidus, she presented the following symptoms which can be interpreted as indicative of hypothalamic dysfunction: General immaturity and hypogenitalism, extreme asthenia, anorexia, malnutrition, apathy, behavioral changes, constipation, increased glucose tolerance, low blood pressure, and circulatory disturbance. It may be theorized that in a case such as this, there is a functional hypothalamic weakness which can account for most of her symptoms. It is also likely that such an individual has a low constitutional energy endowment.

It is probable that the mental picture in such a case is determined to some extent by the previous personality of the individual. The fact that she had a remission of both the physical and mental symptoms following electroshock therapy is suggestive confirmation of the theory that improvement was brought about by a stimulation of hypothalamic autonomic centers.

AUTONOMIC IMBALANCE AT THE HYPOTHALAMIC LEVEL

In schizophrenia, and in some of the other clinical types of mental illness, it is well known

that there are frequently observed cylic changes of various kinds; for example, anorexia may alternate with bulimia, stupor with excitement, elation with depression, increased gastrointestinal motility with decreased motility, etc. In a recent publication, Gellhorn stated that "under physiological conditions the sympathetic division of the hypothalamus inhibits the parasympathetic division and vice versa. The principle of reciprocal innervation seems to be valid for the hypothalamus."

This idea suggests that in certain psychiatric syndromes there may be an imbalance of autonomic function at the hypothalamic level, parasympathetic over-activity being dominant at one time and sympathetic activity at another. The sympathetic system appears to be the accelerator of the organism; the parasympathetic system the brake.

The question arises, of course, as to what can alter the biological activity of the hypothalamus so as to produce an imbalance. It may be theorized that in some people there is an inherent functional weakness; in others the defect may be result of toxic, infectious, or degenerative changes, and in some, dietary deficiency might be a factor. There may, of course, be something inherent or constitutional in the biologic makeup of the individual which facilitates the physiological changes that result in the autonomic imbalance. It is conceivable too that mental stress could play a part.

It is realized, of course, that all schizophrenics do not conform to the pattern of the case reported here. Most psychiatrists are coming to believe that there are different types of schizophrenia based on physiological criteria rather than mental symptomatology. This is confirmed by the Funkenstein tests and the response of some types to the tranquilizers. Further, the physiological manifestations in the same patient are different from time to time. In this paper the terms schizophrenia and psychoses have been used interchangeably. Although the Kraepelinian and Bleulerian terms have a usefulness, it is generally agreed that they have their limitations and that it is possible that all of the so-called functional psychoses and psychoneuroses may have a common neurophysiological foundation.

SUMMARY AND CONCLUSIONS

1. A case is presented of an adolescent girl who exhibited signs and symptoms of both diabetes insipidus and schizophrenia. She was relieved of symptoms of both by electroshock therapy.

2. The theory of the role of autonomic dysfunction at the hypothalamic level in the etiology of schizophrenia is discussed. The superficial manifestations may be determined by the personality and the person's energy endowment.

3. Gellhorn's theory of the mode of action of electroshock in bringing about improvement by stimulating hypothalamic autonomic centers seem applicable in this case.

4. The defect causing the disturbance of autonomic integration may result from physical or mental stress.

Note: A personal communication from Dr. Gellhorn states in part as follows:

"I regret that the Mecholyl® test was not done since I am rather certain that the hypothalamic sympathetic deficiency holds for only a fraction of the schizophrenes. We have now completed tests on a large number of 'normals' and psychotics including schizophrenes and find that the sympathetic reactivity declines with age. The difference between the two groups is greatest at the age of 25 or less, but at this age sympathetic hyper- and hyporeactors are found. I suggested in a paper (Neurol. 6:335, 1956) that the therapy be guided by the autonomic tests. Perhaps you will have an opportunity to do this in other cases."

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A Clinical Evaluation Of Pacatal

This paper reports clinical experience with Pacatal® and discusses mainly the side effects of the drug which occurred in the 92 patients studied. The common side effect was dryness of the mouth and throat. Other reactions were dizziness, headache, photosensitivity, motor restlessness, dermatitis, and nasal congestion.

One case of granulocytopenia cleared when Pacatal was discontinued. Eighty patients complained of blurred vision. Ophthalmologists reported that the drug had caused a toxic paralysis of accommodation. Paralytic ileus occurred in four patients, one of whom required emergency surgery, while others responded to conservative treatment. Depersonalization and feelings of unreality were noted in six patients who were obsessive personalities. One neurotic receiving 50 mg. of Pacatal intramuscularly four times a day developed a toxic psychosis on the fourth treatment day. Toxic symptoms cleared 48 hours after Pacatal withdrawal.

Dosage of Pacatal was between 50 and 600 mg. a day. The drug was a therapeutically active compound, most effective in the psychosis in which acute anxiety, confusion, panic and psychomotor excitement were the predominant symptoms. However, its use was limited seriously by troublesome and potentially dangerous side effects. These toxic properties make the administration of Pacatal hazardous.—*Author's Abstract:* Frank J. Ayd, Jr., M. D., Baltimore, Md.: Dis. Nerv. System, 18(4), April, 1957.



THE primary purpose of this column is to present suitable material pertaining to obstetrics as a "refresher" program for the information and education of Ohio physicians. Brief case summaries with appropriate discussion provide the medium in this issue. However, it is desired to point out that although these two cases, anonymously presented, deal with *diabetes* and pregnancy, they also demonstrate a *dire* need for adequate records, to chart an accurate course of events in the case. All information available to the Committee is published herewith.

TOPIC THIS MONTH:

Maternal Deaths* Involving Diabetes

CASE NO. 54

This patient was a 21 year old, white, primipara who died nine days postpartum (post-cesarean section).

She was seen regularly by her physician beginning at three months. She was known to have had diabetes for three years and was under treatment with diet and insulin, but was not cooperative in adhering to this regime. At 30 weeks' gestation she began to have dependent edema; the following week albuminuria was noted and at about the same time she began to have moderate vaginal bleeding. This became more profuse and she was admitted to the hospital July 6 at 32 weeks for cesarean section. Her blood pressure at this time was 134/92. A classical section was done under spinal anesthesia on the day of admission for pre-eclampsia and a 3 pound living infant was delivered. There was a marginal placenta previa. Estimated blood loss was not reported.

No information concerning the postpartum (postoperative) course was supplied the Committee except that it was "impossible to control the diabetes and nephritis." The patient died eight days after delivery. The cause of death was stated to be eclampsia (although no mention was made of convulsions) and diabetes. No autopsy was obtained.

Cause of death: Puerperal albuminuria and eclampsia; pregnancy with placenta previa marginalis; diabetes mellitus.

COMMENT

Again the Committee felt that the information available in this case is inadequate to justify any sound conclusions. However, the Committee considered the death to be preventable in that the patient failed to cooperate in adhering to diet instructions and diabetic treatment. Nothing is known of the state of her diabetes or the severity of the toxemia on admission to the hospital. Apparently the placenta previa did not constitute a severe emergency and it may be that a more intensive effort might have been made to prepare the patient, prior to surgery and to control both the diabetes and toxemia following delivery. Based upon the meager information available on the patient, the Committee finally voted the case a maternal death, preventable, with responsibility resting on both the patient and personnel.

CASE NO. 28

This patient was a 23 year old, white, Para II who died two days postpartum. She was admitted to the hospital April 7 at 29 weeks of pregnancy, in coma, no fetal heart tones. She had reported to her physician for the first time about one month before, at which time a trace of sugar was found in the urine. She had no hypertension or albuminuria and apparently was having a normal pregnancy. Three or four days before admission, she complained of nausea, vomiting and restlessness and barbiturates were prescribed. Her previous pregnancy was uncomplicated, although there was apparently a known history of diabetes, details not known.

Upon admission to the hospital an internist was called in consultation who treated her for diabetic coma with insulin and intravenous glucose. Antibiotics were given, but no information to suggest a septic course was available in the report to the Committee. Nor were any laboratory data supplied.

The patient remained comatose despite treatment. Several hours after admission she started into labor spontaneously. No fetal heart was detected at any time after admission. Whiffs of Trilene® were given during the second stage. After nine and one-half hours of labor, she delivered a 4 pound, 12 ounce stillborn infant spontaneously; a premature separation of the placenta was noted. No indication of the amount of

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

blood-loss was reported. Following delivery the patient remained comatose and urinary output gradually ceased. She died three days after admission. No autopsy was obtained.

Cause of death: Uremia, nephritis; diabetic coma;diabetes; 7½ month pregnancy delivered stillborn.

COMMENT

The lack of detailed information concerning diagnosis, treatment and the course of the illness, along with the absence of any laboratory findings, made it extremely difficult for the Committee to comment on this case. However, it was thought that the patient's delay in reporting to her physician was a major factor in the fatal course of her illness. The members also felt, in retrospect, that more attention to the initial symptoms of nausea, vomiting and restlessness might have averted the coma. On the basis of the limited information available, the Committee voted the case a maternal death, preventable had the patient been more prompt in reporting to her physician.

COMMENT OF CONSULTANT

The following comment of a consultant who is a specialist in Internal Medicine, was given at the request of the Committee.

Case No. 54. The information in the protocol is so inadequate that no intelligent comments can be made. From the paucity of information one cannot help but be led to believe that there was inadequate control of the patient's diabetes from which she could have died, with marked disturbance in blood electrolytes, particularly hypokalemia. Since she had "nephritis" the electrolyte imbalance was undoubtedly further complicated and there may well have been marked disturbance in sodium elimination or retention depending upon whether the kidneys were "salt losing" or "salt retaining." It is almost imperative that a patient with this picture of pregnancy, diabetes and nephritis be followed closely by a very competent internist in a well-run institution where adequate and reliable laboratory information can be made available at any time.

Case No. 28. This patient also represents a clinical picture of pregnancy complicated by diabetes. From the brief story it is suggested that she became acidotic "three or four days before admission" and undoubtedly died two days postpartum in coma. Information is insufficient to ascertain whether the coma was due to diabetic coma or the coma of uremia, both of which were mentioned. It is quite possible that acidosis (either of diabetic or of nephritic origin) had begun even prior to hospitalization and thus the consultant's management was made extremely difficult by irreversible changes which had already damaged the renal cells as well as cerebral cells.

Just as in Case No. 54, the same observation could be made, that this type of patient must be cared for in an institution where adequate facilities exist to provide more accurate information than is in this protocol. Pregnancy in the diabetic patient always offers extremely serious potential hazards to both mother and fetus, hence both are entitled to expert obstetrical and medical care.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee meeting was held on Wednesday, September 18, 1957. It was presented before the staff of White Cross Hospital at their regular staff meeting. Cases were presented by Dr. William Merryman. Dr. Holzaepfel summarized reports.

Case No. 1: Gravida 0, Para 0, Abortus 0. Patient was admitted on July 16 to the hospital under the medical clinic with history of intermittent vaginal bleeding for eight months duration.

Patient noticed different episodes of pinkish vaginal bleeding starting eight months ago and last two to three days. Menstrual history was non-remarkable; menopause several years ago at about age 50 with no pelvic complaints till present. She consulted a local physician and after pelvic examination was advised to use vaginal douches. During this time two vaginal smears were reported as negative. She was seen in consultation in the Obstetrics and Gynecology Department and on physical examination, the following was found:

General Condition: Satisfactory; *Heart and Lungs:* No abnormalities; *Pelvic:* Mild senile vaginitis. Uterus, small anterior. Cervix, no lesions present. Adnexa negative.

A dilatation and curettage was done on July 23, and reported as: (1) Adenocarcinoma of endometrium, Grade I. (2) Fibrosis of Cervix. Patient had colbalt insertion on July 26. Follow-up: Total hysterectomy and bilateral salpingo-oophorectomy.

Comments: *Patient delay:* Eight months.
Physician delay: None.

Case No. 2: The patient, Gravida I, Para I, was referred to hospital in September. She had had regular periods up to this time but for three years had a history of intermittent bleeding and spotting vaginally. She saw one physician who gave her a series of "shots" to control the bleeding over a three months' period. No history of pelvic examination at this time. Discouraged, she went to another physician who did a cervical biopsy on an obvious lesion. The pathology report was a squamous cell carcinoma of the cervix.

The patient received radium needles in September and December and is living without evidence of disease today.

Comments: *Patient delay:* None.
Physician delay: Three years.

Snake Venom Allergy

A patient may develop hypersensitivity to the venom of a snake which zoologically is related to the one which bit him. For example, a person may become allergic to rattlesnake venom if he was bitten by a cottonmouth moccasin.—Henry M. Parrish, M. D., New Haven, Conn.: *Arizona Med.*, 14:461, August, 1957.

Management of Pregnant Diabetics

(A Ten Year Survey of the Results of Diabetes Complicated by Pregnancy In Two Private General Hospitals—53 Cases)

ROBERT P. KOENIG, M. D.

PLAN OF THE PAPER

THE purpose of this paper is to evaluate the results of diabetes complicated by pregnancy during the past 10 years. Source material was obtained from two private general hospitals. Fifty-three cases were analyzed. The hospitals were located in two distinct regions, one on the east coast and one in the middle-west. Just what care have diabetic women who become pregnant received? What have been the results in private practice of diabetes complicated by pregnancy? This paper is presented in an attempt to answer these questions.

PLAN OF MANAGEMENT

During the past 10 years there has been a steadily changing philosophy in the management of diabetes complicated by pregnancy. In Boston, P. White has had probably the most success with three simple measures: (1) Close medical and obstetrical care of pregnant diabetics. (2) Close hormonal control of the diabetes as well as high doses of progesterone, and (3) Delivery of the infant about the thirty-seventh to the thirty-eighth week of gestation. Her results have been good. This paper attempts to see what other results have been like. An attempt is made to show what type of treatment was given these pregnant women, what kind of delivery they had, and what sort of infants were born of them. Incidentally, there was no supplemental estrogen and progesterone therapy used with any regularity in these two hospitals.

COMPARISON STUDY

A study of pregnant diabetics was undertaken in two private general hospitals in order to compare the results of diabetes complicated by pregnancy. This review considers many aspects of the diabetic mother, her pregnancy and her offspring. (1) The diabetic is classified according to a plan of P. White. (2) Personal data concerning the patient's age, race, obstetrical history, type of delivery, anesthetic used and the method of management are discussed. (3) Complications of pregnancy are listed. (4) Fetal mortality and size of the infant at birth is recorded.

CASE MATERIAL

Fifty-three cases were available for study. Nineteen cases were delivered in a suburban hospital in the New York City area. The other 34 cases were taken from the files of a hospital in Cincinnati, Ohio. Both series of cases consist of all the diabetic women delivered during a 10-year period. Many differences in patient management are evident in the two series of cases. The results illustrate how pregnant diabetics were treated during the past 10 years, in private practice, in two different localities.

The only material available for this study was the patient's chart as it was made up at the time of admission for delivery. Records are inadequate for the careful scrutiny of abortions and other conditions that occurred during the first trimesters of pregnancy. These patients were cared for by private physicians and no clinical histories are available.

EVOLUTION OF CARE

Prior to the advent of insulin in 1921 pregnancy was a severe and usually fatal complication of diabetes. It is known now that women who control their diabetes become pregnant as often as non-diabetic women (Hall). With more frequent pregnancies in diabetic women evolved better management of the diabetes and pregnancy. One plan of management has become most prominent because of success with its use. P. White fostered acceptance of hormonal control of diabetes and delivery of the infant about the thirty-seventh week of gestation. Doctor White's group reported on a series of 163 diabetic pregnancies with a degree of completeness to which few private institutions can lend themselves, even in this day of organized medicine. Her results were outstanding. They show clearly what team management can do for pregnant diabetic women.

The results recorded in most other published series of pregnant diabetics are generally poor. Many of the results in this series are not good. But, it is hoped that an approach of cases such as these will lead to better management of the diabetic when she becomes pregnant. Just as in the non-diabetic pregnancy the result desired is

Submitted April 22, 1957.

The Author

● Dr. Koenig, Cincinnati, is a member of the courtesy staffs of Christ Hospital, Deaconess Hospital, and Bethesda Hospital; clinic assistant in diabetes, University of Cincinnati College of Medicine.

a well mother (with diabetes) and a living healthy infant.

The mortality of infants of diabetic mothers has remained high in most areas. In certain medical centers where close supervision is given the diabetic woman when she is pregnant there has been shown a direct relation between diabetic control and normal motherhood for these women. Many of our city teaching hospitals have organized clinics for pregnant diabetic women. This pattern could be followed in private hospitals, many of which have medical specialty clinics already in existence. These clinics could lend themselves to better medical management of the metabolic defect where economic circumstances prevent private team (medical - obstetrical) care.

CONTROL OF DIABETES

Although there are no specific rules governing delivery in diabetic women, there are clear-cut criteria for the management of the diabetes. Unusually large babies in the past, a family history of diabetes, late abortions and stillbirths all occurring with increased frequency in diabetics, should prompt blood study for its diagnosis. The latent as well as the overt diabetic needs special care during pregnancy. Control of diabetes is a prime requisite. It is best accomplished by frequent close observation of the pregnant diabetic patient in order to ward off any insulting condition that might occur. Delivery should be accomplished about the thirty-eighth week, providing the infant is of normal size. The use of female hormones is a moot point in the management of these patients. Other rules governing normal obstetrical management such as weight control apply to the diabetic patient as well.

OBSTETRIC HISTORIES

Because of the paucity of material available for study at any one hospital these 53 cases were culled from two hospitals.

The first series of cases comes from a 270 bed general hospital in suburban New York City. Material from the case histories of 19 diabetic mothers who delivered between the years 1944 and 1954 were gathered. Although these 19 diabetic mothers had a total of 33 pregnancies with 27 living offsprings there are records available concerning the 19 admissions to the hospital for delivery.

The majority of these cases were handled by a team who had worked together for many years. The internist followed these diabetic women before, during, and after pregnancy in 17 of the 19 cases. (Table 3)

Most of these diabetics were women in their twenties. (Table 2) One mother who was 42 years of age gave birth to a live infant. Seventeen were white Christian women, two were Jewish. All but one were considered mild or moderately severe diabetics. Two of the cases of diabetes were extremely mild, both being discovered during the last trimester. One of the two received insulin therapy while in the hospital for delivery. By the time of her discharge from the hospital the fasting blood sugar was 109 mg. per 100 ml. on diet therapy alone. The other mild diabetic case is worth mention because she was delivered by cesarean section at 36 weeks, giving birth to an 8 pound 1 ounce infant that lived through a siege of hyaline membrane disease of the lungs. No diabetic took more than 100 units of insulin daily. None had severe complications of her diabetes. Class D (Table 1).

One 35 year old mother had diabetes 21 years. They were under adequate control. The expected increased frequency of insulin reactions and occasional mild bouts of acidosis were seen throughout pregnancy. (Table 4) There was no relation noted between the duration and severity of diabetes and large babies and complications of pregnancy and delivery.

Seven of the mothers had insulin reactions during the last trimester. Three had mild acidosis requiring hospitalization. Toxemia without eclampsia was recorded in three cases, and treatment was successful in each case with little trauma to the patient.

THE DELIVERY

No mother died during delivery. One mother died three months postoperatively. She was found at autopsy to have lung abscesses with a tooth imbedded in an abscess. Probably this was an anesthetic death since it was believed that she swallowed the tooth as the section was being performed under procaine local anesthetic. Oddly enough she was the only one mother admitted having active labor. A second mother died during an Addisonian crisis, six years after giving birth

TABLE 1.—CLASSIFICATION OF DIABETICS
(Modified from White)

Class	Degree of Diabetes	Patients	%
A	No Insulin (Diet alone)	2	11
B	Onset after 20 yrs. (less than 10 yrs.)	13	69
C	Onset before 20 yrs. (more than 10 yrs.)	3	16
D	More than 20 yrs.	1	5

TABLE 2.—PATIENT DATA

Age	20 to 42
White race	19
Other races	0
Vaginal delivery	2
Classical section	0
Low transverse cervical	17 (10 Spinal, 3 Local, 4 G/O/E.)
Tubal ligation	6

TABLE 3.—OBSTETRICAL DATA

Total Pregnancies (Gravida)	33
Total Living Children	27
Obstetrician	2
O. B. and Internist	17
General Physician	0

TABLE 4.—COMPLICATIONS

Hypertension	3	16%
Albuminuria	3	16%
Toxemia	3	16%
Polyhydramnios	0	
Acidosis	3	16%
Placenta previa	0	
None of above	16	84%

to a healthy baby. No deaths resulted from pregnancy.

Seventeen of these 19 mothers, or 89 per cent were delivered by cesarean section. The low transverse-cervical method of section was performed in all 17 cases. Trained obstetricians performed all sections. Six of these had the fallopian tubes resected by various methods during sections.

The two mothers who delivered vaginally had labor induced by stripping the membranes between the thirty-fifth and thirty-eighth week. The 35 week old infant was immature (4 pounds, 11 ounces).

INFANT MORTALITY AND MORBIDITY

No multiple births occurred. Nineteen live infants were born of the 19 mothers. (Tables 5 and 6) One infant of the series died. It was a

TABLE 5.—FETAL MORTALITY
(According to Class)

Class	Delivered	Deaths*	Mortality Rate
A	2	0	0
B	13	0	0
C	3	0	0
D	1	0	0

*One neonatal death.

TABLE 6.—FETAL MORTALITY
(According to Gestation Time)

Time	Total	Viable	Premature	Stillborn	Neonatal	Mortality Rate
22 - 31 weeks	0	0	0	0	0	0
32 - 38	19	18	1±	0		5
39 - 42	0	0	0	0	0	0
Total	19	18	1±	0	0	5%

4 pound, 11 ounce infant, delivered at the thirty-fifth week by the vaginal route after stripping the membranes. Delivery was complicated by a difficult breech extraction. He died during the neonatal period. Weights varied (Table 7) be-

TABLE 7.—BIRTH WEIGHTS

Weight	Weeks	Weight	Weeks
9lbs. 9oz.	38	6lbs. 9oz.	36
8	37	8 3	36
8 1	36	8 12	38
7 4	38	5 10	32
5 14	37	7±	38
7±	36	8	36
5 4	32	5 2	36
7 8	38	7±	38
4 11	35	7±	38
6 14	37		

tween 4 pounds, 11 ounces and 9 pounds, 9 ounces. No infant was believed to be 40 weeks at the time of birth. The average weight was 7 pounds, 11 ounces. The only infant morbidity was one case of hyaline membrane disease of the lungs. This infant recovered after one week. Two infants were premature at 5 pounds, 2 ounces (38 weeks); and 5 pounds, 4 ounces (38 weeks). After one week the remaining infants were alive and healthy with only one case of icterus neonatorum noted.

COMPARISON OBSTETRIC HISTORIES

The second series of cases considered admissions to a 370 bed private hospital in the Midwest between the years 1945 and 1955. Only private patients are considered because clinic patients were assigned as private patients to the attending staff. The result of this study reflects the slow trend in changing the manner of managing diabetics who are pregnant. It is noted with optimism however, that now many obstetricians and internists accept 38 weeks as the optimum time of delivery regardless of the method of delivery. Also the team method of diabetic management by obstetrician and internist is noted with increasing frequency.

Charts covering the 10 year period under surveillance are complete, giving detailed information at time of delivery. Thirty-four patients gave birth to 36 infants. The patients are classified according to P. White's method of classification because of simplicity. (See table 8.)

TABLE 8.—CLASSIFICATION OF DIABETICS
(Modified from White)

Class	Degree of Diabetes	Patients	%
A	No Insulin (Diet alone)	2	5.9
B	Onset after 20 yrs. (Less than 10 yrs.)	17	50.0
C	Onset before 20 yrs. (More than 10 yrs.)	13	38.2
D	More than 20 yrs.	2	5.9

Insulin dosage varied greatly from patient to patient and group to group. The only record of insulin dosage was the history given by the patient at the time of admission for delivery. It was felt that this could be of little practical use in classification of the patients.

Ages of the patients varied from 20 to 38 years. Data concerning delivery can be seen in table 9. All 34 patients in this series had diabetes

TABLE 9.—PATIENT DATA

Age	20 - 29	30 - 39
White	24	7
Other	2	1
Vaginal Delivery	7 Spinal 8 G/O/E.	2 Spinal 3 G/O/E.
Classical	3 Spinal 0 G/O/E.	0 Spinal 1 G/O/E.
Low Transverse	9 Spinal 1 G/O/E.	
Tubal Ligation	5	

established prior to the admission to the hospital for delivery. Thirty-one whites and three Negro patients were delivered. Twenty patients were delivered vaginally although the exact number induced or the number delivered spontaneously is not determined in this survey. Since the series dates back to 1945 it is noted that four classical sections and 10 low transverse-cervical sections were performed (14.7 per cent) in this non-Catholic institution. The usual reasons for the tubal ligation were complicated diabetes, multiparity or a high incidence of abnormal babies.

TEAM MANAGEMENT

Thirty-four mothers had a total of 84 pregnancies. Forty-five children were living at the time of this study. Unfortunately a relatively small group (35 per cent) of the mothers in this

series received close observation by an internist and one or more obstetricians. Forty-seven per cent of the mothers were under the care of their obstetrician alone. Eighteen per cent of this series were cared for by general physicians alone. Fetal mortality rates demonstrate the obvious need for closer control of diabetes during pregnancy (table 10). The 34 mothers who had

TABLE 10.—OBSTETRICAL DATA

Gravida		85	
Total Living Children		45	
Maternal Care	Living	Deaths	%
O. B. alone	18	6	3.3
O. B. & Internist	12	1	.83
General M. D.	6	1	16.6
Abortions		11	
Stillbirths		17	
Neonatal Deaths		4	
Premature Deaths		5	

84 pregnancies included 13 per cent abortions, 20 per cent stillbirths, 4 per cent premature deaths, and 5 per cent neonatal deaths. There is no detailed information concerning patient management other than the 36 deliveries which took place at this institution.

As noted in table 11, only 26, (5 per cent) of

TABLE 11.—COMPLICATIONS

Hypertension	9	27
Albuminuria	4	12
Toxemia	18	53
Polyhydramnios	1	29
Acidosis	11	32
Placenta previa	3	9
None of above	9	27

the diabetic mothers did not have any severe complications during pregnancy. Toxemia, bouts of acidosis, coma, polyhydramnios, placenta previa, albuminuria, and hypertension occurred in different degrees, in the other 73.5 per cent of pregnant women. Many women had more than one of these complications. However, no maternal death is recorded. Eastman states that "Almost all maternal deaths today from diabetes complicated by pregnancy are due to neglect."

INFANT MORTALITY AND MORBIDITY

The infants were delivered at or near term in most instances. Eighteen, or one half of the infants were delivered between the thirty-seventh and fortieth weeks. The mortality rate for all classes was high. Eighteen mothers were delivered between the twenty-second and thirty-sixth week. Eight of the mothers were delivered between the fortieth and later weeks.

TABLE 12.—FETAL MORTALITY
(Class)

Class	Delivered	Deaths	Mortality Rate
A	4	2	50%
B	18	4	22%
C	11	3	33%
D	1	1	100%

TABLE 13.—FETAL MORTALITY
(Gestation Time)

Time	Total	Viable	Pre-mature	Still-births	Neonatal	Mortality Rate
22 - 31	3	0	2	1	0	100%
32 - 38	25	19	2	4	0	24%
39 - 42	8	5	0	2	1	38%
Total	36	24	4	7	1	33%

The mortality rate for the group of 12 infants whose mothers were managed by an internist-obstetrical team was 8.3 per cent—a figure comparable to that of P. White. The mortality rate for the other 24 cases delivered by a general physician or obstetrician alone was 29 per cent. One infant whose mother had had diabetes for 21 years died during the neonatal period.

The babies of this series delivered of diabetic mothers were not excessively large (table 14).

TABLE 14.—BIRTH WEIGHTS

Weight	Weeks	Weight	Weeks
7lbs. 5½oz.	40	7lbs. 8oz.	34
7 10	37	4	27
8 14½	36	6 6½	38
8 4	40+	5 12	37
4 9	32	6 11	37
4 9	33	Stillbirth	30
Macerated stillbirth	40+	9 4½	40
	36	7 10	40
8 9½	37	Section	34
2 6½	29	8 2	38
8 5½	40	8 12	40
Dead monster	36	7 7	32
10±	36	6 4¾	32
6 ½	37	Stillbirth	40
7 4	36	8 4	40
7 2	35	Stillbirth	33
5 14½	35	Stillbirth	33
8	38	5 17	38

Several factors probably are important in the relatively normal size of these infants. Present-day diabetic diets, regardless of degree of observation by the patient are believed to be superior to diets followed 20 years ago. Insulin is used freely in young diabetics. In general, diabetic women receive more medical attention before and during pregnancy which may account not only for their ability to be fertile but also to have healthy offsprings.

The average of the 27 weights recorded is 7 pounds, one-third ounce, just equal to the normal average birth weight. This fact alone tends to place emphasis on diabetic care of the mothers during pregnancy rather than upon the optimal time of delivery about the thirty-eighth week. However, the group of infants delivered between the thirty-second and thirty-eighth weeks had a mortality rate which was 24 per cent or 12.5 per cent less than the 36.5 per cent mortality rate of the 39 to 42 week infant. These figures are in keeping with the feeling that delivery of diabetic mothers should take place at an optimal time. Many of the infants who died were of mothers who had acidosis one or more times during pregnancy.

DISCUSSION

Diabetes complicated by pregnancy requires management of the diabetic complication just as carefully as the management of the mechanics of pregnancy. Delivery about the thirty-seventh or thirty-eighth week of gestation has been shown

by White and others to result in a greater number of well infants. The second series of cases presented demonstrates that closer team (internist-obstetrician) care of pregnant diabetic women is necessary in private hospitals. One private hospital in which team care has been practiced 10 years demonstrates the results that can be expected. Although no statistics are presented in this paper, the usual increased number of insulin reactions in young pregnant diabetic women was observed. In the future perhaps glucogen or some similar substance might aid in control of insulin reactions. The need for closer control of the diabetes during pregnancy is evident from both series of cases.

Although the first series is small, the 19 cases are remarkable. It is hoped that it demonstrates what team management can do in the case of diabetics who become pregnant. Perhaps these methods of induced delivery are drastic. One case ended in death of the mother probably due to the anesthetic used at the time of induction. Also the one death of an infant was listed as prematurity. Perhaps later delivery might have prevented this death. The high rate of tubal ligations prevents further cases of difficult diabetic pregnancies. It is noted that most of these 19 women were in their twenties, so that we should have expected the best of results from these controlled young diabetics. They are not the complicated juvenile diabetic patients whom we dread to see pregnant. The excellence of these results is unquestioned, but are we solving the problem of diabetes complicated by pregnancy by cutting off our source of the problem?

SUMMARY

1. Fifty-three cases of diabetic women who become pregnant are discussed. Care of the women differed in two hospitals.

2. Obstetrician-internist *team* management is shown to be of value in the management of diabetes complicated by pregnancy by reducing complications of both pregnancy and of diabetes in the mother and by reducing the infant mortality.

3. Maternal morbidity and mortality of diabetes complicated by pregnancy was shown to be controlled in these two series of cases.

4. Details concerning diabetic care, the type of delivery and anesthesia, and tubal ligations are presented.

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KEEPING UP WITH MEDICINE

• IT IS GENERALLY agreed that, whatever the basic causes of atherosclerosis may be, hypercholestrolemia is almost certainly a predisposing or contributory factor in its pathogenesis. The causes and nature of this hypercholesterolemia and its role, direct or indirect, in atheroma formation remains a matter of conjecture. Still, the well documented correlation between atherosclerosis and hypercholestrolemia, measured directly, or in terms of lipo-protein concentrations, would seem to justify the intensive efforts being made to find means of decreasing serum cholesterol levels.

* * *

• INFECTIOUS MONONUCLEOSIS may be related to infectious hepatitis and may occur simultaneously with thrombocytopenic purpura.

* * *

• BIOTIN DEFICIENCY may cause an eczematous dermatitis.

* * *

• ISOTOPIC STUDIES have shown that the Mammalian liver is a site of intense phospholipid synthesis which suggests that these compounds can be readily catabolized in that tissue.

* * *

• IN GENERAL, fatty acids are not metabolized unless they are in combination with coenzyme A.

* * *

• IT HAS BEEN suggested by the work of Leon Goldman and his associates that hydrocortisone, used intradermally as a therapeutic agent, acts by a paradoxical mechanism, producing local tissue damage and yet inhibiting the development of an inflammatory reaction to the damage it has caused and at the same time depresses the inflammatory reaction already present in the skin from the disease.

* * *

• IT IS of significance that women with psychoneurotic symptoms at the menopause will usually be found to have had psychoneurotic symptoms at a previous time.

* * *

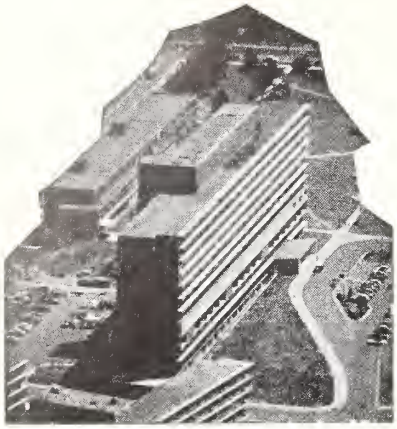
• INFANTILE myoclonic seizures, or "jacknife convulsions"—a mysterious form of epilepsy believed linked to malformation of or damage to the brain at the beginning of life—generally strikes and disappears before the child is five, although mental retardation may follow in its wake.

* * *

• A CONSIDERABLE number of children with Fibrocystic Disease of the Pancreas also have chronically diseased paranasal sinuses.

* * *

• IT IS beginning to appear that instances of papular urticaria are due to infestations rather than allergy. Recently fleas were identified as the cause in 21 out of 30 cases.—J. F.



A Case Record

From The University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Ralph J. Johansmann, M. D., President

Presented by Harry E. LeFever, M. D., Emmerich von Haam, M. D., and Wolfgang Zeman, M. D.

Edited by Dr. von Haam

PRESENTATION OF CASE

THE patient, a white female aged 14, was admitted to University Hospital with the chief complaint of lack of menstruation and poor vision. It was noted at birth that the patient had an enlarged clitoris, and at 2 years of age pubic hair developed. After a very thorough study, however, the physicians failed to reach a definite conclusion. At 4 years of age the patient was explored surgically and the ovaries and uterus were reported normal. The patient's voice became rather deep and husky at the age of 7, and at 9 years of age coarse hair appeared on her lower legs and thighs.

By the age of 13 the patient had failed to show any breast development or menstruation. Hair began to appear beneath her chin and on the sides of her face. There were complaints of decreasing visual acuity for distant vision. During the past two to three years she reported attacks of frontal headache which consisted of a constant aching pain, usually present in the morning on awakening. These pains occurred approximately once or twice every three to four months. They were not associated with vertigo or convulsions but sometimes vomiting occurred during these episodes. The last one had been experienced two weeks before admission. She was admitted to University Hospital for evaluation of her endocrine status.

The past history revealed the usual childhood diseases from which the patient had recovered without incident and scarlet fever at the age of 5. The review of systems yielded the following additional information: The distant vision was reported to be poor, but the near vision was reported normal. She wore glasses to correct her myopia. She had never complained of diplopia or blurring. She had had no marked weight loss or gain; the present weight was 154 pounds. She was a sophomore in high school and was a good student scholastically.

Submitted Sept. 3, 1957.

PHYSICAL EXAMINATION

The patient was well developed, rather obese and in no acute distress. She appeared bright, alert and cooperative. She had a definite masculine appearance with a male adolescent hair distribution of the arms, legs and face. The blood pressure was 138/88, pulse 104, respirations 18, temperature 98.6°F. The pupils were round, regular and equal and reacted to light and accommodation. The thyroid was reported to be just barely palpable. The breasts showed no female breast development.

The lungs and heart were normal to percussion and auscultation. The abdomen showed no abnormal findings. Examination of the genitalia showed an enlarged clitoris measuring 2 to 3 cm. in length. No labia minora were present. The vagina was small and infantile. On rectal examination no cervix was felt. The anterior rectal wall was firm and muscular. The extremities were not remarkable, nor was the spine.

LABORATORY STUDIES

The examination of the urine was not remarkable. The white blood cell count was 9,400 with normal differential count; the hemoglobin was 15.9 Gm.; the red blood cell count 5.28 million; serum phosphorus was 4.9 mg.; the alkaline phosphatase 7.1 units; the total plasma proteins were 7.4 Gm., albumin 4.5, globulin 2.2; the serum sodium was 148 mEq., the potassium 4.2 mEq., the blood chlorides 104 mEq.; the blood urea nitrogen was 11 mg.; the blood sugar 107

mg.; the blood calcium 11 mg.; blood cholesterol 125 mg. The serology was negative for syphilis. The glucose tolerance test showed a fasting blood sugar of 107 mg.; it rose in the first half hour to a peak of 172 mg. and was 145 mg. after one hour, 86 mg. after two hours, 86 mg. after three hours and 90 mg. after four hours.

The basal metabolic rate was —15 corrected. Protein-bound iodine was 5.5. The 24 hour radioiodine uptake was 46 per cent of the normal. Urinary excretion of radio-active iodine was 39 per cent in 24 hours. 11-oxysteroids secretion was .6 mg. in a 24 hour urine sample. The 17-ketosteroids secretion amounted to 82 mg. in 24 hours on several determinations. The follicle stimulating or gonadotropic hormone content in the urine was zero in the 24 hour sample.

X-RAY STUDIES

X-rays of the dorsal spine showed some slight demineralization of the vertebrae. X-rays of the lumbar spine were normal. A plate of the soft tissue of the abdomen was also normal. The bones of the pelvis showed no abnormality. The pelvis was of female configuration, although somewhat small. X-rays of the skull showed considerable thickening of the calvarium with excess lacunae scattered throughout the diploe. The dorsal sella was grossly distorted and there appeared to be erosion of the floor and of the posterior clinoid processes. The x-ray diagnosis was osteoporosis of the thoracic spine, destruction of the sella turcica and erosion of the floor of the sella and of the posterior clinoids. The bone age appeared normal.

OPHTHALMOLOGIC EXAMINATION

The patient had been complaining of failing vision for about 6 months and had been unable to read well during the past month. Examination of the visual fields showed an irregular bitemporal hemianopsia. The extraocular movements were intact, the conjunctivae were clear, the pupils were regular and reacted both to light and accommodation. On examination of the fundi the discs were oval and very pale; the upper and nasal borders were blurred and the arteries were very narrow. The diagnosis was that of bitemporal hemianopsia, incongruent type, and bilateral optic nerve atrophy possibly secondary to severe papilledema.

HOSPITAL COURSE

Because of the imminent threat to the optic nerves, the patient was subjected to craniotomy. A severe hydrocephalus was found, which was drained to relieve the pressure. Immediately postoperatively a tracheotomy was performed. During the night following the operation the patient developed hyperthermia up to 107° F., which could not be controlled by aspirin and cold packs. The pulse rose to 160, and the blood pressure fell to 60/20. She suddenly vomited bright red blood, and later coffee-ground material. She was given Levophed,® blood, and intravenous ACTH. She also received intravenous dextrose with penicillin, normal saline and more whole blood. The urinary output remained over 3,000 cc. a day. The day following the operation, the patient's temperature again rose to 107°, she vomited a very large amount of bloody material and expired.

CLINICAL DISCUSSION

Dr. LeFever: We are confronted with a very interesting, very fascinating, and very tragic case. We are asked to attempt to determine why there was this extraordinary deviant from the norm in the sexual development, and why there have developed in the course of her illness certain unmistakable intracranial complications. The patient was admitted because she complained about failure to menstruate and an increasingly poor vision. Her endocrine symptoms dated back 12 years and could never be explained. She had a large clitoris, a husky voice, severe hirsutism of the male type, and was slightly obese. She appeared bright, alert and cooperative, and was a good student. She had slight hypertension and examination of her eyes showed papilledema.

The laboratory findings disclosed a slightly increased glucose tolerance and evidence of hypothyroidism. The excretions of the 17-ketosteroids were 10 times above the normal. The x-ray studies were interesting and revealed an erosion of the floor of the sella with atrophy of the clinoid processes. The visual field examination showed an irregular and bitemporal hemianopsia. With these findings it was felt that this child's vision was in jeopardy and that some operative procedure was indicated.

CRANIOTOMY

Craniotomy revealed a severe hydrocephalus which was drained to relieve pressure. The only definite way to diagnose a hydrocephalus is by means of angiography followed by ventriculography, which was not done. When we say we drain a hydrocephalus, we mean that we put a needle into the ventricles and drain the fluid, but we know full well that the fluid will reaccumulate within a period of a very few hours unless we produce something of a permanent drainage as it is done by the Torkeldsen procedure where a catheter is placed into one or both lateral ventricles and brought out through the cranium and underneath the scalp, and then reinserted into the cisterna magna, thus by-passing, the aqueduct of Sylvius and the fourth ventricle. I would think that this had been done since it was stated that a drain was inserted in order to relieve pressure. Following the operation she developed hypotension, shock, and began to vomit blood and expired two days later.

By bitter experience, we have come to conclude that at a clinical pathologic conference it is far better to seize upon one single lesion to explain

the signs and symptoms rather than to indulge in a multiplicity of diagnoses. I think we might profitably concentrate our discussion to the area about the sella turcica since a lesion in this localization could best account for most of the signs and symptoms which this patient presented.

Let us begin, then, with a tumor in the anterior portion of the sellar area, which arises from a remnant of an embryological rest—the so-called Rathke's pouch tumor. Such a tumor is very frequently cystic and may press upon the optic nerves and produce a very clear-cut bitemporal hemianopsia with an extreme degree either of optic atrophy or of choking of the discs, depending whether there is a generalized increase of intracranial pressure or just a direct pressure upon the optic nerves. This tumor also may press upon the third ventricle to the extent that a bilateral internal hydrocephalus may result. However, those tumors are always accompanied by signs of hypopituitarism either of the Lorain or of the Froehlich type. Since I do not think that our patient falls into either category we can safely exclude this tumor from further consideration.

Tumors arising from the neural portion of the pituitary are so rare that they are almost inconsequential from a percentagewise basis. That leaves us with tumors arising from the endocrine portion of the hypophysis of which there are three varieties. A chromophobe adenoma will produce symptoms of hypopituitarism and never a Cushing-like syndrome. Also it is rare for a chromophobe adenoma to extend beyond the confines of the sella turcica and to exert pressure upon the third ventricle to the extent that a bilateral internal hydrocephalus could ensue. It is therefore my opinion that neither from an endocrine point of view, nor from a neurological point of view are we dealing with a chromophobe adenoma.

EOSINOPHILIC TUMORS

The eosinophilic type of pituitary tumors may produce gigantism during puberty and acromegalia in an adult. But again, this gigantism is associated with infantile genitalia and is never associated with premature or precocious sexual development. Although a bitemporal hemianopsia may result from such a tumor, the tumor rarely extends beyond the confines of the sella itself.

Now what about a basophilic adenoma? Well, it produces premature sexual development, polycythemia, an increase of the blood pressure and osteoporotic changes in the bone due to demineralization. However, these tumors are rarely larger than a match head and I can't conceive that this could ever produce either a pressure upon the optic nerves or an internal hydrocephalus due to compression of the third ventricle or occlusion in the foramen of Monro or the aqueduct of Sylvius.

So I suggest that we abandon the sella as the site of a lesion which could be responsible for this child's difficulties and look somewhere else. Well, immediately posterior to this area lies the pineal gland, tumors of which may produce precocious sexual development with macrogenitosomia, hirsution, and a deep masculine voice like this girl had. Because of its anatomical location, this tumor can also produce an early occlusion of the aqueduct of Sylvius and an enlarged third ventricle. Pressure from such an enlarged third ventricle then may destroy the posterior clinoid process, erode the floor of the sella turcica and also exert pressure upon the optic nerves. Because of the location of the pineal gland immediately above the quadrigeminate plate, pineal tumors may also exert pressure upon the superior and inferior colliculus.

Pressure upon the superior colliculus produces a syndrome known as Parinaud's syndrome, in which the patient is unable to look above a horizontal. We are informed that this child's extraocular movements were perfectly normal, and therefore I concluded that this syndrome was not present. Pressure upon the inferior colliculus produces a difficulty in hearing, which is especially noticeable in the high note range and which can be detected by audiometric methods before it becomes clinically manifest. While a pineal tumor could account for the loss in vision and for the bilateral internal hydrocephalus, I hesitate to make such a diagnosis because the child never was unable to look above a horizontal. I feel quite certain the ophthalmologist, the neurosurgeons and the rest of the house staff would have picked this up and also the hearing difficulties. So I conclude the clinical picture in our patient is not due to a pineal tumor.

McEVAN'S' SOUND

Now, what else can occur in this area to produce this picture? Well, a few months ago I saw such a child—age 6. He had a heavy beard and a mustache and the most prodigious sexual development I have ever seen. In addition, if you struck the head it gave a peculiar sound, which is known as the cracked pot sound, or McEvan's sound, and he also had choked discs. He had a curious vascular anomaly, known as a hamartoma, which may be present at birth and may continue to grow or remain dormant and which occurs in the pineal recess area or about the cistern of the pons and may extend into the temporal lobes. It also can occlude the aqueduct and produce a bilateral internal hydrocephalus.

I was very much interested in the fact that the patient had an "irregular" bitemporal hemianopsia, which the ophthalomogist called of "incongruent" type. I think they are implying that this was a forme fruste and a bitemporal hemianopsia is something so definite that we don't have to hesitate about it. It is either there or not. But if there has been a choking of the disc and if there has been a peripapillary fibrosis, then a gun-barrelled type of irregular vision may

result in which the visual field may be cut down in an irregular fashion with a temporal encroachment of the field. I think that this lesion has certainly occluded the aqueduct and that the third ventricle was enlarged and destroyed the posterior clinoids and part of the floor of the sella. I think that this lesion had exerted pressure upon the optic nerves; if not, the atrophy was secondary to a choking of the discs.

The fact that her headaches were greater in the morning and that they were accompanied by vomiting suggests an ebb and flow in her hydrocephalic pressure which occurs quite often in an extreme degree of hydrocephalus which is always worse in the early morning hours. I believe that her bilateral internal hydrocephalus was produced by an occlusion at the posterior portion of the third ventricle, if not of the aqueduct of Sylvius.

CAUSE OF DEATH

Now, why did she die? Well, I gather that she has had a Torkeldsen drain placed in the lateral portion of the lateral ventricle and that this drain was brought down into the cisterna magna to provide a permanent drainage for the increased intracranial fluid. Now, very frequently after release of an excessive pressure, changes take place in remote areas of the brain. As this fluid is suddenly drained, there may occur a shift of the brain stem which can lead to a damage of the hypothalamic area. This can lead to the appearance of ulcers in the esophagus, stomach or intestines which have been first observed and described by Cushing and which bear his name. These ulcers may lead to gastrointestinal hemorrhage and rapid destruction of tissues. We have seen a complete dissolution of the esophagus within 24 hours as a result of such a neural lesion. So, I would conclude that she died as a result of a neurogenic ulcer and that her hyperthermia, her increase in the pulse rate, and the drop of her blood pressure was secondary to a medullary decompensation. Her primary lesion was a hamartoma, with pressure upon the third ventricle and bilateral internal hydrocephalus.

GENERAL CLINICAL DISCUSSION

QUESTION: How do you explain the endocrine changes?

DR. LEFEVER: Well, I think they accompany this hamartoma, and I neglected to mention that such a hamartoma will not affect the cranial nerves. The hamartoma completely engulfs them and forms a capsule around them. But you do observe precocious sexual development.

QUESTION: Would you say that this girl was born with this lesion?

DR. LEFEVER: Yes.

DR. ELSON: I disagree with the radiological interpretation of her bone age. Bone-agewise she is at least 18 years old, which would be compatible with a masculinizing tumor. Her skull picture is compatible with a chronic increase of intracranial pressure. You certainly don't expect a suprasellar or intrasellar tumor to produce this much change in the skull.

QUESTION: What percentage of craniopharyngiomas do not calcify?

DR. LEFEVER: I would say about 60 per cent.

CLINICAL DIAGNOSIS

1. Hamartoma of pineal region with
   a. Macrogenitosomia and precocious sexual development.
   b. Bilateral internal hydrocephalus.
2. Cushing ulcers with gastrointestinal hemorrhage.
3. Postoperative medullary decompensation with
   a. Hyperthermia.
   b. Hypotension.

PATHOLOGICAL DIAGNOSIS

1. Astrocytoma of quadrigeminus plate with
   a. Bilateral internal hydrocephalus.
2. Congenital bilateral hyperplasia of adrenal cortex and
   a. Adrenogenital syndrome.
3. Cushing ulcer of the stomach with gastrointestinal hemorrhage.
4. Postoperative medullary decompensation.
5. Early bronchopneumonia.

PATHOLOGICAL DISCUSSION

DR. VON HAAM: I shall confine my discussion only to the autopsy findings and will let Dr. Zeman, who just recently joined our staff as a very competent neurologist, discuss the lesions of her central nervous system.

The autopsy revealed a young adult female with a general body development of definite masculine character as described in the physical examination. The heart appeared normal in size and shape. The lungs showed a diffuse hemorrhagic edema with foci of early bronchopneumonia. The spleen, liver, and pancreas showed no significant changes. The stomach showed extensive recent ulcerations involving the cardia and extending toward the pylorus along the small curvature. Microscopically there was extensive necrosis of the mucosa with submucosal edema, hemorrhage and bacterial colonization. It was a severly autolytic lesion with little inflammatory reaction and typical of the lesion seen in disease of the central nervous system. The small and large intestines showed no ulceration.

The adrenals weighed 55 grams as compared to a normal weight for this age of about 16 grams and showed microscopically a marked hyperplasia of the innermost layer of the adrenal cortex or the zona reticularis, which according to Selye is credited with the production of the adrenal testoids. The ovaries were small and showed microscopically no corpus luteum or maturity follicles. The uterus was involuted but other-

wise normal. The clitoris measured 4 by 1 by 1 cm. and appeared prominent. The pituitary gland weighed only 583 mg. and looked microscopically like the pituitary of a growing child. The thyroid was slightly enlarged and showed a mild diffuse colloid goiter.

In summary, then, we have a patient with an obvious central nervous system lesion which has produced a rather extensive Cushing lesion of her stomach. Her endocrine symptoms can be explained by an idiopathic and non-neoplastic diffuse hyperplasia of the adrenal cortex with special emphasis on the zona reticularis. The clue to this lesion was the excessive excretion of 17-ketosteroids which is not present in the precocious sexual development found in lesions of the central nervous system or in pineal tumors.

DR. ZEMAN: The operation on this patient was done under the presumption that the lesion was in the area of the sella. Therefore a lateral bone flap was turned and the area of the sella turcica visualized. A cyst was found which was located anterior to the pituitary stalk and posterior to the optic chiasm. This cyst was partly removed, and not until then was it realized that this was not a true cyst but was just a bulging of the lamina terminalis of the third ventricle, as Dr. LeFever had predicted. At this point it was realized that a lesion most likely would be found further dorsally in the area of the aqueduct, and a Torkeldsen operation was contemplated. However, it was felt that the patient would recover from this operation, which unfortunately she did not, and no Torkeldsen was done.

THE BRAIN FINDINGS

The brain weighed 1250 grams. There was a prominent pressure conus of the inferior cerebellum. The third ventricle was markedly dilated and formed a cyst-like protusion causing pressure on the sella turcica. The lateral ventricles were moderately enlarged. The aqueduct of Sylvius was compressed to a slitlike space by a pale tumorous nodule arising in the quadrigeminus plate. Microscopically it consisted of all sorts of astrocytes and spongioblasts and could be recognized as a grade II astrocytosis in the lamina quadrigemina of not too high a degree of malignancy.

I was very much impressed with Dr. LeFever's attempt to bring the whole condition in this patient together under one heading, and I just wonder whether this would not be appropriate and permissible in this particular case. As you all know, there seems now to be recognized some relationship between the release of steroid hormones and the occurrence of tumors. We remove now the pituitary and the adrenals in order to stop the rapid growth of various types of malignant tumors, and the question comes up whether there could be any relationship between her high level of 17-ketosteroids and the growth of her neoplasm. I would off-hand answer this question in a negative way, as there is no sufficient evidence for such assumption. However, there are two facts which I would like to point out.

In the first place, tumors in the lamina quadrigemina are extremely rare. In his most recent communication Henschon from Stockholm reported on 3,200 cases of intracranial neoplasma, only 14 of which were tumors in the lamina quadrigemina. These tumors are almost exclusively low grade tumors either of the spongioblastic or astrocytic variety and in many a case it is questionable whether we are really dealing with an astrocytoma or with an astrocytic gliosis, which question of course sheds some light on the problem of the pathogenesis of these tumors. As you all know, in many a case of so-called congenital hydrocephalus internus we find an astrocytic gliosis in exactly the same area as we found the tumor in this particular case, and for a long time it was disputed as to whether the nature of this gliosis was blastomatous or reactive to some intra-uterine infection of the central nervous system.

NEOPLASIA?

Spiller felt that such a lesion represented a very low grade type of blastoma, but he was opposed later on by more progressive neuropathologists, who claimed that they had evidence for the inflammatory nature of such lesions in this area, and I was taught that these lesions which produce internal compression of the aqueduct are usually inflammatory in nature. It was not until 1946 when Globus could show that in embryos spinal fluid could seep out in this area under increased spinal fluid pressure, leading to a proliferation of the cells which could ultimately produce a lesion responsible for compression of the aqueduct.

I could not tell whether this was true in our case or not, but I would like to point out that if we have a reactive process in this area which for some reason or another becomes blastomatous, we might well assume that under conditions of extreme steroid production, as in this patient, a relatively low-grade blastoma might be stimulated to grow faster. This is as far as I can agree with Dr. LeFever's admirable attempt to explain this patient's condition by a single disease process.

Methyl Bromide Poisoning

Methyl bromide is used as a fumigant for fruit and nuts to kill eggs and larvae. When it was first used its toxicity was known to experts but apparently not to distributors or users. Hence a number of workers were seriously poisoned. It is a mild local irritant and a central nervous system depressant, causing symptoms similar to alcohol intoxication, but differing from alcohol in that but a few exposures may produce degenerative changes in the central nervous system. It may also cause degenerative changes in the liver.—C. H. Thienes, M.D., *California Med.*, 87:135,1957.

Medical Records . . .

Importance of Good Record Keeping Stressed in Bulletin Issued by Hospital Accreditation Commission; Essential Standards Enumerated

EVERY physician will agree, no doubt, that medical records are an important tool in the practice of medicine; serve as a basis for planning patient care; provide a means of communication between the physician and other professional groups; furnish evidence of the course of the patient's illness and treatment, and serve as a basis for evaluation of the care rendered the patient.

In a bulletin by Dr. Kenneth B. Babcock, director of the Joint Commission on Accreditation of Hospitals, it was pointed out that it considers the quality of medical records as an indication of the quality of patient care given in the hospital. Obviously, the role of the physician in the record keeping system is very important.

The Commission has established the following standards of record keeping which it believes are essential for good patient care and these are enumerated here because of the physician's interest and his important part in making them effective:

* * *

I. CONTENT

Medical records should contain the following information:

1. **Identification data**

2. **Provisional diagnosis**—There should be a provisional or admitting diagnosis made on every patient at the time of admission. If a patient requires hospitalization, the hospital staff deserves this information to proceed intelligently.

3. **Chief Complaint**

4. **Present Illness**

5. **History and Physical Examination**—Only physicians and house staff are competent to write or dictate medical histories and physical examinations. All pertinent positive and negative findings should be recorded. Nurses, medical record librarians, or secretaries should not be permitted to take medical histories.

6. **Consultations**—Consultations imply an examination of the patient and the patient's record. The consultation note should be recorded and either signed or authenticated by the consultant.

7. **Clinical Laboratory Reports**—The original signed laboratory report should be entered in the patient's record. Duplicates are filed in the laboratory. Reports from laboratories outside the hospital are acceptable in lieu of tests performed in the hospital if the following safeguards are maintained:

Editor's Note: At the 1957 Annual Meeting of the OSMA, the House of Delegates instructed *The Journal* to publish material on hospital accreditation. The first article of a series on this subject appeared in the August issue, explaining the principles underlying the work of the accreditation commission. The second article in September dealt with recommendations of the AMA Stover Committee; the third in October, with Medical staff meetings. This is the fourth article.

In subsequent articles as information is available *The Journal* will present suggestions and information from the Joint Commission and answers by the Commission to many varied questions on the activities of the Commission, standards set by the Commission, hospital administrative problems, etc.

a. Work is done in a laboratory approved by the city or state. Laboratory work performed in a physician's office by a technician, nurse, or office assistant is not acceptable. Since the hospital is held responsible for the quality of laboratory work reported in the medical record, it must limit outside laboratory work to approved laboratories.

b. The test is recent enough to be pertinent to the individual case. For example, a serological test for syphilis or an Rh determination done any time during the prenatal period would be acceptable. A urinalysis done prior to 48 hours of admission would not.

c. The original laboratory report is made part of the medical record.

8. **X-Ray Reports**—The original signed radiological report should be entered in the patient's record. Duplicates are filed in the department.

9. **Tissue Report**—Since all tissues removed in surgery are sent to the laboratory, at least an acknowledgment that the tissue has been received and a gross description should be made part of the record. If a microscopic examination is done, a description of the findings should be made a part of the record. Whether or not a microscopic examination is done should be determined by the medical staff and the pathologist according to the rules and regulations of the hospital.

10. **Treatment — Medical and Surgical** — All treatment procedures should be documented in the medical record. Except in cases of grave

emergency, the patient should receive a complete diagnostic work-up before surgery. Operative notes should be dictated immediately after surgery and should contain both a description of the findings and a detailed account of the technique used and tissues removed.

11. **Progress Notes**—Progress notes are important in that they give a chronological picture and analysis of the clinical course of the patient. The frequency with which they are made is determined by the condition of the patient.

12. **Final Diagnosis**—A definitive final diagnosis based on the terms specified in the Standard Nomenclature of Diseases and Operations should be written.

13. **Summary**—A summary of the patient's condition on discharge and course in the hospital is valuable as a recapitulation of the patient's hospitalization.

14. **Autopsy Findings**—When an autopsy is performed a complete protocol of the findings should be made a part of the record.

II. SIGNATURES

1. In hospitals without house officers the attending physician should separately sign the history, physical examination, operative report, progress notes, drug and other orders, and the summary. Standing orders should be reproduced on the record and signed by the physician.

2. In hospitals with house officers, the attending physician should countersign at least the history, physical examination and summary written by the house officer. Aside from the fact that this is a legal requirement in many states, it is a protection to the individual physician. It is not considered necessary to countersign progress notes or drug and treatment orders written by house officers. In all instances a physician should sign the clinical entries which he himself makes.

3. A single signature of the physician on the face sheet of the medical record does not suffice to authenticate the entire content of the record.

4. The use of rubber stamp signatures is acceptable under the following strict conditions:

a. The physician whose signature the rubber stamp represents is the only one who has possession of the stamp and is the only one who uses it.

b. The physician places in the administrative offices of the hospital a signed statement to the effect that he is the only one who has the stamp and is the only one who will use it.

5. Initials in place of a full signature are acceptable provided that the initials can be recognized as having been placed there by a particular physician who can be identified by those initials.

III. OBSTETRICAL RECORDS

There should be a prenatal history and physical examination on every obstetrical patient. If the hospital and medical staff permit and records are of good quality on forms approved by the hospital, a copy of the prenatal record kept by the physician in his office may be substituted for a history and physical examination done in the hospital.

IV. READMISSIONS

If a patient is re-admitted within a month's time for the same condition, the previous history and physical examination with an interval note will suffice.

V. NURSES' NOTES

The Commission has no requirements concerning nurses' notes. It is the responsibility of the local medical and nursing staffs to develop policies concerning the type and extent of nurses' notes to be kept.

VI. FORMS

1. The Joint Commission on Accreditation of Hospitals recommends no specific medical record forms. Records are evaluated on the basis of content and whatever forms the hospital finds most useful and acceptable. It is common experience that check-off lists do not adequately provide sufficient information to substantiate the diagnosis and treatment.

2. Short Forms—A short form medical record is acceptable in certain treatment and diagnostic cases of a minor nature which require less than 48 hours hospitalization. Short forms may be appropriate for such conditions as tonsillectomies, cystoscopies, lacerations, plaster casts, removal of superficial growths, and accident cases held for observation. The short form should at least include identification data, a description of the patient's condition, pertinent physical findings, an account of the treatment given and any other data necessary to justify the diagnosis and treatment. The record should be signed by the physician.

VII. FILING AND MAINTENANCE OF MEDICAL RECORDS

1. Current records should be completed insofar as possible within 24-48 hours.

2. After discharge, records should be completed insofar as possible within 10-15 days.

3. A system of identification and filing to insure the rapid location of a patient's medical record should be maintained. The unit number system is suggested; however, a serial number or modification of this is acceptable.

4. Records should be indexed according to disease, operation, and physician.

5. If medical records are coded, it is suggested that the Standard Nomenclature be used.

VIII. PRESERVATION OF MEDICAL RECORDS

The Joint Commission on Accreditation of Hospitals has no standards governing the preservation of medical records. The length of time

a medical record is preserved is a matter which should be determined by the local hospital and local laws.

Methods of preservation by microfilming or other means of storage is a decision for the individual hospital to make.

IX. OWNERSHIP

The medical record is the property of the hospital and is maintained for the benefit of the patient, the physician and the hospital. It is the responsibility of the hospital to safeguard the information on the record against loss, tampering, or use by unauthorized persons.

Health Insurance Protection Still on Increase Among Americans

Voluntary health insurance against costs incurred through sickness and accident continues to spread its protective coverage over more and more Americans.

The Health Insurance Institute, taking a forward look to year-end growth figures, predicts that by December 31, 1957, over 123-million people in the U. S. will be protected by some form of health insurance designed to help pay hospital, doctor or other medical care bills. This represents close to 75 per cent of the total U. S. civilian population.

Breaking down the national totals on health insurance coverage for 1957, an estimated 109-million persons will be protected for surgical expenses, 74-million will have regular medical expense protection, 13-million will be insured against major medical expenses, and 43-million for loss of income coverage, in addition to the 123-million protected against the cost of hospital bills. Biggest growth in the type of coverage in recent years has been major medical expense insurance which helps to absorb the cost of serious, or catastrophic, illness.

Health insurance today protects more people than any other single type of insurance in force, the Institute reports.

Total health insurance benefits paid out this year by insurance companies, Blue Cross-Blue Shield and miscellaneous plans, will amount to an estimated $4.2-billion, as compared to $3.6-billion in 1956, the Institute said. This accounts for a major contribution to the nation's over-all medical bill.

Pediatric Cardiology

The Cook County Graduate School of Medicine has announced a one-week intensive practical course in the diagnosis and treatment of congenital malformations of the heart and of rheumatic heart disease in infants and children, starting December 2. Another course in pediatric cardiology will begin December 9. Details may be obtained by writing the school at 707 S. Wood Street, Chicago 12, Ill.

New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since September 1, 1957. The list shows the County in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

CARROLL COUNTY
Harold C. Dowell, Carrollton
Robert C. Lanzer, Minerva
John W. Luttrell, Malvern

CLARK COUNTY
John H. Sheets, Springfield

COLUMBIANA COUNTY
Robert G. Marquardt, East Liverpool

CUYAHOGA COUNTY
Clarence E. Everhart, Jr., Cleveland
Frank Jelercic, Cleveland
Thomas S. Kelley, Cleveland
James E. Nousek, Jr., Cleveland
Stanley Post, Cleveland
Lucia C. Trandafir, Cleveland

FRANKLIN COUNTY
Clarence E. Carnahan, Jr., Worthington
George T. Harding, IV, Worthington

HAMILTON COUNTY
Stephen Hornstein, Cincinnati
Berthold Pembaur, Cincinnati
George M. Wyatt, Cincinnati

MARION COUNTY
Paul S. Derian, Marion
Edward W. Gerber, Marion
William H. Hoffman, Marion
Harold E. Manhart, Prospect
Gerald W. Morris, Marion
Vernon A. Nichols, Marion
Ray C. Smith, Marion
Robert L. Stuber, Marion

MEDINA COUNTY
Bennis E. Grable, Lodi
Fabio Rodriguez, Wadsworth

MONTGOMERY COUNTY
Wilfred H. Weltge, Dayton

OTTAWA COUNTY
V. William Wagner, Port Clinton

SUMMIT COUNTY
M. Kenneth Kaufmann, Akron
Elliot Migdal, Akron
E. Blaine Studer, Akron

Several Ohioans Will Participate In Bahamas Conference

The Fourth Bahamas Medical Conference will be held at the Fort Montagu Beach Hotel in Nassau, Bahamas, December 1-15. Registration fee is $75. Special rates are available at the hotel. Reservations should be made (10 cents stamp for air mail) to: Mr. John L. Cota, Gen. Mgr., Fort Montagu Beach Hotel, Nassau, Bahamas.

Ohioans on the program are: Dr. Earle B. Kay, Cleveland; Dr. Donald W. Smith, Columbus; Dr. Henry Zimmerman, Cleveland; Dr. Leonard Gottesman, Cincinnati, and Dr. Chauncey D. Leake (Ph. D.), Columbus.

Columbus VA Area Medical Office Will Be Moved to Indianapolis

The Veterans Administration Area Medical Office in Columbus will be moved to Indianapolis, Indiana, "when space can be obtained and adequate notice can be given to personnel," an announcement from VA said. Two other similar area offices are being moved as part of a geographical realignment of VA areas.

The St. Paul, Minn., office will move to Omaha, Nebraska; and the St. Louis office will move to Dallas, Texas. Other offices are located in Boston, Trenton, N. J., Atlanta and San Francisco.

INTRAVENOUS Compatible with common IV fluids. Stable for 24 hours in solution at room temperature. Average IV dose is 500 mg. given at 12 hour intervals. Vials of 100 mg., 250 mg., 500 mg.



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Many physicians advantageously use the parenteral forms of ACHROMYCIN in establishing immediate, effective antibiotic concentrations. With ACHROMYCIN you can expect prompt

INTRAMUSCULAR Used to start a pa-
tient on his regimen immediately,
or for patients unable to take oral
medication. Convenient, easy-to-use,
ideally suited for administration
in office or patient's home. Supplied
in single dose vials of 100 mg., (no
refrigeration required).

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Hydrochloride
Tetracycline HCl Lederle

IN MINUTES -- SUSTAINED FOR HOURS

control, with minimal side effects,
over a wide variety of infections -
reasons why ACHROMYCIN is one of to-
day's foremost antibiotics.

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Proceedings of The Council . . .

Statement of Policy on Influenza Adopted; Financial Problem Of Aid for Aged Program Discussed; Miscellaneous Actions

THE Council of the Ohio State Medical Association had its annual Fall meeting at the Granville Inn, Granville, Ohio, on September 14 and 15, 1957. Delegates from Ohio to the American Medical Association and chairmen of certain committees were guests.

By official action, the minutes of meetings of The Council held on April 27 and May 16, 1957, were approved.

MEMBERSHIP DATA

President Martin requested the Executive Secretary to submit a report on membership. He did and the report was as follows: OSMA members as of September 10, 1957, 8,902, of which 7,922 have affiliated with the A. M. A.

PRO-RATING OR WAIVER OF ANNUAL DUES

By official action The Council authorized the pro-rating and waiver of State Association dues for the calendar year 1958 as follows:

1. **Pro-rating of dues for new regular members:** Dues for new members affiliating in the third quarter of 1958 shall be $15.00; dues for new members affiliating in the fourth quarter of 1958 shall be $10.00. Pro-rating of dues shall not apply to former members re-affiliating.

2. Annual Ohio State Medical Association dues for a physician serving a hospital internship or residency during the first five years following graduation from medical school (excepting the time spent in military service), who meets the membership eligibility requirements of the Ohio State Medical Association and who is accepted into membership by a component medical society, shall be $7.50. Such intern or resident member shall be offered a subscription to *The Ohio State Medical Journal* at one-half the regular subscription rate.

3. The following procedure shall apply with respect to OSMA annual dues of members on extended active duty in the military service or in the United States Public Health Service:

1. State Association dues for 1958 shall be waived for members on extended active duty in the military service or U. S. Public Health Service.

2. State Association dues for 1958 shall be waived for physicians who were members of the Association in 1957 and who enter such services during the calendar year 1958 before the payment of 1958 dues.

3. A refund of membership dues will not be made if a member enters such services in 1958 after his 1958 dues are received at the Columbus Office of the Association.

4. The secretary-treasurer of each county medical society shall be requested to cooperate with the Columbus Office in assembling the names of physicians entitled to waiver of dues under the foregoing provisions.

50-YEAR AWARDS

Fifty-Year award certificates and emblems for physicians entitled to them in 1957 were distributed to members of The Council. Councilors were urged by Dr. Martin to get in touch with the county medical societies involved and arrange for the presentation of these certificates and emblems at an early date.

CONSTITUTION AND BY-LAWS

Extensive changes in the Constitution and By-Laws of the Jefferson County Medical Society, comparable to the provisions of the new model constitution and by-laws, were considered. The Executive Secretary reported that these had been reviewed by Mr. Stichter, legal counsel, and that he recommended they be approved. By official action, the revised constitution and by-laws of the Jefferson County Medical Society was approved.

The Portage County Medical Society submitted a new constitution and by-laws, based on the model constitution and by-laws, which had been adopted by that society on Augut 21. The Executive Secretary reported that he found the document in line with the new model constitution and by-laws for county medical societies and recommended its adoption. The Council, by official action, approved the revised constitution and by-laws of the Portage County Medical Society.

Action was deferred on revisions adopted by the Mahoning County Medical Society, pending a review by Mr. Stichter, legal counsel. Dr. Pease, Councilor of the Eleventh District, reported that the Lorain County Medical Society is contemplating the adoption of a new constitution and by-laws, based on the model constitution and by-laws, and would probably submit this for consideration by The Council at its next meeting.

By official action, The Council authorized a committee, consisting of President Martin, Mr. Stichter and Executive Secretary Nelson, to review and pass on changes adopted by county medical socities in their constitutions and by-laws in order to expedite the handling of such matters.

The Executive Secretary, for the information of members of The Council, stated that the OSMA By-Laws require that associate members

of local societies must be members of the Ohio State Medical Association. This was reported due to the fact that some county societies apparently misunderstand this and do not consider associate members as eligible for State Association membership.

REPORT OF COMMITTEE ON MATERNAL HEALTH

Dr. Anthony Ruppersberg, Jr., chairman of the Committee on Maternal Health, was introduced to The Council. He presented a report on the activities of that committee.

The report consisted primarily of the presentation for Council action, "Guiding Principles for Obstetric Care," drafted by the committee and which the committee plans to have distributed throughout the state as recommendations to members of the medical profession of Ohio.

The Council, after reviewing the document, gave it official approval and ordered proper publicity given to the principles. These principles are published on pages 1328-1329 of this issue. Dr. Ruppersberg and his committee were commended by The Council for their fine work.

REPORT ON INFLUENZA SITUATION IN OHIO

Dr. Martin then introduced Dr. Ralph E. Dwork, Director, Ohio Department of Health, and Dr. Winslow J. Bashe, epidemiologist, Division of Communicable Diseases, Ohio Department of Health, who had been invited to meet with The Council to discuss the influenza situation.

Dr. Dwork reviewed the developments with respect to the incidence of influenza and the production of the new vaccine. He stated that Ohio probably would receive approximately 5 per cent of all vaccine made, inasmuch as the voluntary distribution system is based on the percentage of population.

Dr. Dwork pointed out that his department had established recommendations regarding priorities for use of the vaccine and recommendations regarding dosages. He said he thought it would be helpful if The Council would approve these recommendations.

Dr. Dwork said he was setting up an advisory committee and would like to have representation on that committee from the Ohio State Medical Association.

Following a general discussion and questions and answers, The Council took the following actions:

1. Adopted a statement of policy with respect to the influenza situation and immunization generally. (See Page 1176 October issue.)

2. Approved the issuance to county medical societies of a question and answer memorandum to assist the county societies in answering questions from the news media and the public generally. (See Page 1178 October issue.)

3. Authorized Executive Secretary Nelson to represent the Association on the influenza advisory committee which Dr. Dwork referred to.

4. Endorsed the priority and dosage recommendations suggested by the Ohio Department of Health.

1958 COUNTY SOCIETY OFFICERS CONFERENCE

Plans for the 1958 Annual Conference of County Society Officers and Committeemen in Columbus were discussed. By official action, The Council selected the date of Sunday, March 2, for the conference and selected the Deshler-Hilton Hotel as a place for the conference. It authorized the Executive Secretary and members of the Columbus office staff to arrange the program, in consultation with members of The Council, individually, and with officers of certain county medical societies.

The Council, in taking this action, also decided to hold a regular meeting of The Council in the Columbus office on Saturday afternoon and evening, March 1.

1958 ANNUAL MEETING

Dr. A. Carlton Ernstene, chairman of the Committee on Scientific Work, made an extensive report to The Council on plans for the 1958 meeting in Cincinnati, April 15, 16, 17. Members of The Council were supplied with minutes of a joint conference between that committee and officers of the sections held on August 25 and minutes of a meeting of the committee held on September 8.

After receiving Dr. Ernstene's report, The Council took the following action:

1. Adopted a schedule of events for the 1958 Annual Meeting and designated the Netherland Hilton Hotel as the headquarters. (See pages 1325 and 1326 this issue for annual meeting schedule.)

2. Approved the recommendation of the committee that Dr. David B. Allman, Atlantic City, President of the American Medical Association, and Mrs. Allman be invited to attend the banquet and that Dr. Allman be invited to address the Association at that time.

3. Approved the recommendation of the committee that Dr. F. J. L. Blasingame, Wharton, Texas, the newly-appointed general manager of the A. M. A., be invited to address the General Session on Wednesday afternoon, April 16.

4. Approved the showing of the new A. M. A. film on professional liability entitled "The Doctor Defendant."

5. Approved the decision of the committee that it would not be feasible to comply with a request of the Cincinnati Academy of Medicine's council that a seminar on civil defense be included in the annual meeting program. At the same time The Council approved a recommendation of the Committee that the Cincinnati Academy of Medicine, if it deems such a seminar of vital importance, consider presenting such a session on either Tuesday evening, April 15, or on Monday, April 14, the day preceding the opening of the OSMA meeting. In taking this action the committee and The Council stated that the OSMA

would cooperate on the handling of details, promotion, etc., if the Cincinnati Academy decided to sponsor the seminar.

6. Approved the recommendation of the committee that Dr. Edwin H. Ellison, Columbus, be reappointed to the Committee on Scientific and Educational Exhibits to serve for a term of five years; and that Dr. Geo. J. Hamwi, Columbus, be reappointed as chairman of that committee for the ensuing year.

7. Approved the recommendation of the committee that the following policy, which had been originally adopted in 1952 with respect to the Scientific and Educational Exhibit, be reaffirmed for the guidance of the committee in handling details in connection with the Scientific and Educational Exhibit in 1958:

"Presentations in the Scientific and Educational Exhibit should be limited to exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations, out-of-state physicians or agencies on invitation, and voluntary health organizations — all applications for exhibits to be subject to the approval of the Committee on Scientific and Educational Exhibits."

8. Approved the recommendation of the committee that the Ohio Division of the American Cancer Society be advised that there would be no objection to its holding a meeting in Cincinnati on the day preceding the OSMA meeting.

Appreciation to Dr. Ernstene and the committee was officially expressed by The Council.

During the discussion of annual meeting details, Dr. Ernstene suggested that perhaps the Committee on Scientific Work should be enlarged in order to provide more personnel in planning for the annual meeting program. By official action, The Council approved this idea, and instructed the Executive Secretary to prepare a proposed amendment to the By-Laws of the Association for consideration by the House of Delegates at the 1958 Annual Meeting.

REPORT OF COMMITTEE ON RURAL HEALTH

The report from the Committee on Rural Health was presented by Dr. Edmond K. Yantes, chairman of that committee. This report included the following information:

The committee selected Mr. William A. Hutchison, Smithville, as recipient of the 1957 rural medical scholarship.

The committee believes that there should be an investigation of the reasons for the small number of applicants for the scholarship and a study of the advisability of perhaps discontinuing the scholarship and using such funds for other worthy projects.

That a change should be made in the schedule for the lectures to medical students at Ohio's three medical schools, namely, that a one-day lecture program be held at Ohio State University and at the University of Cincinnati—probably for junior and senior medical students—and that the present plan of holding six weekly lectures be continued at Western Reserve University. It was pointed out that this change would be experimental and temporary and that the reason for the change was to try to stimulate greater attendance at the lectures.

The 1957 preceptorship program was an overwhelming success and the committee has agreed to expand this program during the ensuing year. The committee plans to carry on the preceptorship program along the same lines as in 1957. Preceptors will be selected from county seat towns or rural areas—outside of the metropolitan communities.

The committee recommends that the Association again print and distribute personal health records for us by 4-H Clubs in their activities throughout the state.

The committee suggested that consideration be given to the possibility of distributing a health record similar to the 4-H document to physicians and hospitals for general use throughout the state, but stated it could not make a specific recommendation on this, pending a study of the cost involved.

By official action, The Council approved the report submitted on behalf of the Committee on Rural Health and expressed appreciation to that committee for its customary fine work during the past year.

COMMITTEE ON SCHOOL HEALTH

Mr. Page presented a report on behalf of the Committee on School Health. His report was officially approved by The Council and the committee thanked for its activities. In his report Mr. Page stated that the Committee, through its Chairman, Dr. Shaffer, has offered assistance to the Ohio Congress of Parents and Teachers with regard to the new expanded school health program of the PTA. Replacing the "Summer Roundup," (a single health appraisal upon school entrance) the new policy, recommended by the National Congress of Parents and Teachers, advocates continuous health supervision of the child from birth through school years, preferably by his own physician and dentist. Complete text of the new PTA recommendation was published in the January, 1957, issue of *The Ohio State Medical Journal*. It was also reported that members of the Committee and its staff are continuing to provide consultation to county medical societies, universities, colleges and schools on school health matters. The Committee is working with the State Planning Committee for Health Education on plans for the 1958 Ohio Conference on Physicians and Schools, and will sponsor an educational exhibit at the annual convention of the Ohio Congress of Parents and Teachers the last week in October.

AID FOR AGED FEE SCHEDULE

At the invitation of The Council, representatives of the Ohio Department of Public Welfare and Division of Aid for the Aged attended the

meeting to discuss the serious financial problem confronting the health care program of the Division of Aid for the Aged. Those present were: Dr. Richard D. Minor, Assistant Director, Ohio Department of Public Welfare; Mr. Thomas D. Weiler, Chief, Division of Aid for the Aged; Dr. Charles Wilcox, Medical Director of the Division of Aid for the Aged; Mrs. Elinor Hixenbaugh, Supervisor of Social Services; and Mr. Ira Lamoreaux, Executive Secretary of the Division of Aid for the Aged. They presented facts and figures regarding the question and answered many questions from members of The Council.

After this conference The Council, by official action, instructed the President to send a communication to Governor O'Neill, expressing the opinions of The Council on this matter. The letter, which was sent by Dr. Martin, read as follows:

"I have been instructed by The Council of the Ohio State Medical Association to convey to you the sincere desire of the association to assist in every possible way in finding a solution for the serious problem which confronts the State Division of Aid for the Aged in relation to its health care program.

"The Council on the week-end of September 14-15 held an extended conference with Mr. Minor, assistant director of the Ohio Welfare Department, and officials of the Division of Aid for the Aged.

"Our board thoroughly understands the financial problem confronting the division which caused it to make drastic curtailments in the health care program. This has been reported by us to the medical profession of the state.

"Speaking for the physicians of the state, The Council regrets that the State of Ohio did not appropriate sufficient funds to meet the obligation which the state has assumed—namely, to carry on an adequate health care program for the recipients of aid for the aged.

"The Council hopes that you and others in positions of authority will continue to exert every effort to correct this situation. The medical profession will support your efforts, you may be sure, as it is convinced that an adequate health care program for recipients of aid for the aged cannot be carried on under the existing financial setup and under the restrictions which have been placed on the program."

WOMAN'S AUXILIARY TO THE OSMA

The following, representing the Woman's Auxiliary to the Ohio State Medical Association, appeared before The Council to discuss with The Council certain problems of the Auxiliary: Mrs. F. R. Frederick, Urbana, President; Mrs. William H. Evans, Youngstown, Mrs. A. Paul Hancuff, Maumee, and Mrs. Karl F. Ritter, Lima, Past Presidents of the Auxiliary.

The delegation presented a report showing the growth of the auxiliary and the expansion of its activities. They pointed out that the auxiliary needs financial aid or personnel from the OSMA in order to carry on its present program of activities. Following a general discussion, and questions and answers, The Council, by official action, referred this matter to the Committee on Auditing and Appropriations, suggesting to that committee that it hold conferences with the Woman's Auxiliary Advisory Committee and with the special committee from the auxiliary which appeared at today's meeting.

The Council advised the delegation from the auxiliary that a special membership certificate, which could be issued to local auxiliaries indicating that the local auxiliary is a component unit of the state auxiliary, would be prepared by the Columbus office and supplied to the state auxiliary for distribution to local auxiliaries.

SUBCOMMITTEE ON MEDICAL RESEARCH LEGISLATION

A report was presented by the Executive Secretary on behalf of the special Subcommittee on Medical Research Legislation, based on a meeting of that committee held on June 18, 1957.

The report pointed out that House Bill 384, which will make it possible for medical research and teaching institutions and organizations to secure abandoned and unwanted dogs, became effective September 13 and that in the near future the committee would send a memorandum to various institutions and research and teaching organizations offering certain recommendations and suggestions. The report also stated that in all probability a conference of representatives of participating institutions would be held some time after the first of the year in order for them to exchange experiences and ideas regarding the functioning of the new law. The report of the committee, as submitted, was approved by official action, and the committee commended and congratulated for its successful activities.

OSMA FUTURE PLANNING COMMITTEE

President Martin asked Dr. R. L. Meiling, Columbus, chairman of the OSMA Future Planning Committee, to present a report on activities of his committee. Dr. Meiling presented the following report, which was accepted by The Council with appreciation to Dr. Meiling and his commitee:

"The OSMA Future Planning Committee is pleased to note that in May, 1957, $10,000.00 was deposited by the OSMA in the Buckeye Federal Savings and Loan Association of Columbus as a beginning of a 'building fund.'

"The Columbus Chamber of Commerce wrote and offered their assistance in finding a location in Columbus for the new OSMA home, if and when funds are available for its purchase or construction. We asked the Chamber of Commerce to investigate the possible purchase or long term lease of property reclaimed for

'through-ways' in the heart of Columbus, such property as might be in excess of the needs for the roads, per se.

"On September 13th Dr. Martin, Dr. Sherburne and Dr. Meiling visited the property at 750 East Broad Street, Columbus (the F. W. Schumacher home) at the invitation of the Huntington National Bank and the Preston Cooke & Company of Columbus. This property will be for sale in the near future. The committee did not feel that the building on this property was adaptable to the needs of the OSMA.

"The committee is cognizant of the action of the OSU Board of Trustees in authorizing the lease of property on the OSU campus to the Ohio State Bar Association for its future headquarters building.

"The committee will continue to maintain interest in the long range project of the OSMA."

MILITARY ADVISORY COMMITTEE

A communication from Dr. Drew L. Davies, Columbus, chairman of the Military Advisory Committee, was read and discussed. In the communication Dr. Davies pointed out that, due to the fact that the Doctors' Draft Act is no longer in effect, the activities which he had been performing as chairman of the committee would be greatly curtailed and he recommended that the financial arrangement between him and the Association be terminated as of October 1, 1957.

The Council, by official action, approved this recommendation and voted appreciation to Dr. Davies for a splendid job over the past several years in handling military questions involving Ohio physicians.

The following official actions were taken by The Council on questions submitted to them for consideration:

LABORATORY STANDARDS

Referred to the Committee on Public Relations and Economics a resolution adopted by the House of Delegates at the 1957 Annual Meeting, requesting The Council to name a committee to study the matter of establishing qualifications and standards for diagnostic laboratories, such committee to report its recommendations to the 1958 session of the House of Delegates.

OHIO MEDICAL ASSISTANTS SOCIETY

Deferred action on a constitution and by-laws presented by the Ohio Medical Assistants Society, pending further study of such document by the special committee named to confer with that society. This action was taken on the recommendation of Dr. George W. Petznick, Cleveland, chairman of the special committee.

GROUP LIFE INSURANCE FOR OSMA MEMBERS

Authorized President Martin to name a small committee to confer with insurance agents on matters pertaining to a group life insurance program for members of the OSMA and that the committee, in the first instance, to confer with the four agencies which already have requested authority to present such a program to the Association.

JOURNAL PRINTING

Instructed the Executive Secretary to advise the Danner Press, Akron, that the Association is satisfied with the present arrangements with the Stoneman Press for the printing of *The Ohio State Medical Journal* and that bids on this printing contract should not be opened at this time.

CINCINNATI GRIEVANCE CASE

Requested the Executive Secretary to convey to the council of the Cincinnati Academy of Medicine the appreciation of the OSMA for the manner in which it had settled a grievance case.

REPORT ON AMEF

Approved a report by Mr. Saville, reporting for Dr. Merrill D. Prugh, Chairman of the Ohio Committee of the American Medical Education Foundation. Mr. Saville stated that a total of $27,724.78 had been contributed by 587 donors in the 1956 campaign in Ohio. This amount included $8,443.53 from the Woman's Auxiliary to the OSMA. In addition, 2,535 medical alumni in Ohio contributed $113,527.92 directly to the alumni funds of their own schools. Dr. Martin urged members of The Council to actively support and promote the 1957 AMEF campaign in their respective districts.

REPORT ON NEW YORK AMA MEETING

Received reports from the Ohio delegates to the AMA on the June meeting held in New York City. Such reports made special reference to the disposition of the Ohio resolutions. Reference was made to the detailed article on the AMA meeting published in the July issue of *The Ohio State Medical Journal.*

PROFESSIONAL LIABILITY INSURANCE RATES

Received a report from the Executive Secretary that arrangements have been worked out with the Department of Insurance for notification of the OSMA when and if an application for increase in the premium rates on professional liability insurance is filed with the Department, so the OSMA may file a protest and ask for a hearing if it desires to do so. This action was taken pursuant to a resolution adopted by the House of Delegates at the 1957 Annual Meeting.

CONTRIBUTION TO OHIO LEAGUE FOR NURSING

Authorized a financial contribution of $100.00 to the Ohio League for Nursing to assist it in its nurse recruitment program.

SOCIAL SECURITY FOR PHYSICIANS

Studied communications from individual members and from certain county medical societies suggesting that the Association modify its op-

position to compulsory social security coverage for physicians and officially requested each county medical society to take a poll of its members as to their opinion on the coverage of physicians in the Social Security program. The action stated that each county society should be requested to instruct its delegate, or delegates, so they could vote on this question at the meeting of the House of Delegates in Cincinnati next April; that county medical societies should provide information on the number of votes cast and the number for or against this issue; that the Columbus office advise the county medical societies of actions taken by the AMA and about the poll conducted by the OSMA two years ago; that each society set up its own educational program on this matter.

NORTHEAST OHIO BLUE CROSS PLAN

Received a report from the Executive Secretary regarding the merger of the Blue Cross Plans in the Cleveland and Akron areas into a new Northeast Ohio Blue Cross Plan and the negotiations taking place now between the new plan and Ohio Medical Indemnity with respect to joint administrative details.

MATTERS REFERRED TO THE COMMITTEE ON GOVERNMENT MEDICAL SERVICES

Referred a question with regard to revisions in the Veterans Administration Fee Schedule to the Committee on Government Medical Services for consideration.

Referred to the Committee on Government Medical Services a communication from the Ohio Society of Internal Medicine with regard to the fee allowed for a special examination by the Bureau of Vocational Rehabilitation in connection with the "disability freeze" provision of the Social Security program.

Referred to the Committee on Government Medical Services letters of complaints regarding the United Mine Workers Health Program and Administrative regulations of the Division of Aid for the Aged.

NEW COMMITTEE ON MEDICAL HISTORY AND ARCHIVES

Adopted a motion by Dr. Meiling that a special Committee on Medical History and Archives be appointed to consider the matter of collecting historical material, and the possibility of later publishing such material in book form.

Following reports by the Councilors, The Council adjourned to meet on Saturday night, December 14, and Sunday, December 15.

Attest: CHARLES S. NELSON,
Executive Secretary.

The American Goiter Association, 149½ Washington Ave., Albany 10, N. Y., is again offering the Van Meter Prize Award and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland.



have you made your contribution to medical education?

Whether you contribute direct to your Alma Mater or your State or County Medical Society or, through the American Medical Education Foundation —

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Chicago 10, Ill.

New Chemotherapy

ARALEN® *in* RHEUMATOID ARTHRITIS

Extensive studies of rheumatoid arthritis and related collagen diseases—in this country and abroad—have shown the antimalarial Aralen phosphate to be highly effective and well tolerated in a large percentage of patients.

Clinical Results with Aralen in Rheumatoid Arthritis

Author	No. of Cases	Major Improvement	Minor Improvement	No Effect
Haydu[1]	28	22	5	1
Rinehart[2]	25	12	4	9
Freedman[3]	50	43	3	4
Bagnell[4]	108	77	12	19
Bruckner[5]	36	32	0	4
Cohen and Calkins[6]	22	17	3	2
Scherbel et al.[7]	25	?	8	8
Total	294	212 (72%)	35 (12%)	47 (16%)

- Success dependent upon persistent treatment
- Often of benefit where other agents have failed
- Remissions on therapy well maintained
- Remission of 3 to 12 months possible even if treatment is interrupted
- Tachyphylaxis not evident

GENERAL EFFECTS:

- Patient feels better
- Patient looks better
- Exercise tolerance increases
- Walking speed and hand grip improves

LABORATORY EFFECTS:

- E. S. R. may fall slowly

ANALGESICS AND STEROIDS:

- Requirements usually reduced or eliminated

JOINT EFFECTS:

- Pain and tenderness relieved
- Mobility increases
- Swellings diminish or disappear
- Muscle strength improves
- Rheumatic nodules may disappear
- Even severe or advanced deformity may improve
- *Active* inflammatory process usually subsides
- Joint effusion may diminish

DOSAGE:

Aralen is cumulative in action and requires four to twelve weeks of administration before therapeutic effe become apparent.

Latest information indicates that an initial dail dose of 250 mg. of Aralen phosphate is preferab to the higher doses sometimes recommended. However, if side effects appear, withdraw Aralen for several days until they subside. Reinstate treatment with 125 mg. daily and, if well tolerated, increase to 250 mg. The usual maintenance dose is 250 mg. daily.

New Chemotherapy

INDICATIONS:

- Rheumatoid arthritis, acute or chronic —with or without adjunctive therapy.
- Spondylitis
- Arthritis associated with lupus erythematosus or psoriasis

THEORY OF ACTION:

Aralen appears to suppress or induce remission of rheumatoid inflammatory processes by inhibiting adenosinetriphosphatase.

HOW SUPPLIED:

Aralen phosphate: 250 mg. tablets in bottles of 100 and 1000.
125 mg. tablets in bottles of 100.

Tolerance:

Aralen is usually well tolerated. Toxic effects are usually mild and to date have been transitory in nature, disappearing completely either on continuance or cessation of therapy or on reduction in dosage.

Gastrointestinal disturbances (e.g. nausea, rarely vomiting, diarrhea, abdominal cramps, anorexia) are frequent manifestations of intolerance. Temporary blurring of vision (due to interference with accommodation) is also relatively frequent.

Pleomorphic skin eruptions (e.g. lichenoid, maculopapular, purpuric), although generally mild, may preclude the use of an optimum dosage schedule. If a skin reaction persists on a reduced dosage schedule, or recurs after reinstitution of treatment with gradually increasing doses, discontinue Aralen till the lesion again disappears and consider resuming treatment with Plaquenil® (brand of hydroxychloroquine).

Less frequently transitory vertigo, headache, lassitude, or neurological disturbances, such as nervousness, irritability, emotional change, and nightmares have been reported. Instances of unexplained slight gradual weight loss as the patient's general health and arthritic condition improved have been mentioned. Occasional instances of bleaching (depigmentation) of the hair have been described.

Although an occasional instance of leukopenia, with normal differential count, has been reported (WBC about 3000), it has not proved troublesome because it has always been reversible on discontinuance, or diminution of the dose. Even spontaneous reversal may occur while full dosage is maintained.

Caution:

Aralen is known to concentrate in the liver and, although hepatic damage has never been reported, the drug should be used with caution in the presence of liver disease. In the presence of severe gastrointestinal, neurological, or blood disorders, the drug should be used with caution or not at all. If such disorders occur during the course of therapy, the drug should be discontinued. Concomitant use of gold or phenylbutazone with Aralen should be avoided because of the tendency of these agents to produce drug dermatitis.

Clinical Comments:

Of fifty patients receiving Aralen therapy, "43 have become really well; that is, they have no stiffness, and any pain that occurs can reasonably be attributed to use of joints affected by secondary degenerative changes. They have no evidence of joint inflammation, but may have a raised erythrocyte sedimentation rate. They have little or no need for analgesics." *Freedman*[2]

"One hundred and twenty-five private patients have been carefully followed clinically and haematologically while receiving well over 200 patient-years of chloroquine [Aralen] therapy. The results are considered good in 70%, one-half of these cases being in remission. Improved work performance, sedimentation rate, and hemoglobin levels paralleled the major objective gain in this 70%. 90% of them remained on chloroquine [Aralen] therapy, half for more than two years. Classical peripheral rheumatoid arthritis, spondylitis, arthritis of juvenile onset, and rheumatoid disease with psoriasis, all appeared to respond about equally well.

"It is suggested that chloroquine comes closer to the ideal for long-term, safe, control of rheumatoid disease than any other agent now available." *Bagnall*[4]

"Out of the 36 rheumatoid arthritis cases we treated . . . favorable results were obtained in 32 cases. *Bruckner et al.*[5]

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1. Haydu, G.G.: Rheumatoid arthritis therapy: a rationale and the use of chloroquine diphosphate, *Am. J. M. Sc.* 225:71, Jan., 1953.
2. Rinehart, R.E.: Chloroquine therapy in rheumatoid arthritis, *Northwest Med.* 54:713, July, 1955.
3. Freedman, A.: Chloroquine and rheumatoid arthritis, a short-term controlled trial, *Ann. Rheum. Dis.* 15:251, Sept., 1956.
4. Bagnall, A.W.: The value of chloroquine in rheumatoid disease, a four year study of continuous therapy, read at the Ninth International Congress on Rheumatic Diseases in Toronto, Canada, June 23-28, 1957.
5. Bruckner I., and Rosenzweig, S.: Treatment of chronic rheumatoid arthritis with synthetic antimalarials, read at the Ninth International Congress on Rheumatic Diseases in Toronto, Canada, June 23-28, 1957.
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7. Scherbel, A. L., Schuchter, S.L., and Harrison, J.W.: Comparison of effects of two antimalarial agents, hydroxychloroquine sulfate and chloroquine phosphate,

Winthrop LABORATORIES NEW YORK 18 N Y

Developments in AFA Program . . .

Aid for Aged Authorized Hospitalization Period Extended by Order Of the Governor; Attorney General Rules on Local Responsibility

THERE were four major developments in Ohio's Aid for the aged program as the November issue of *The Ohio State Medical Journal* went to press. They were:

(1) Execution of an order by Governor O'Neill whereby AFA recipients rated as hardship cases will be given hospitalization at state expense beyond the recently imposed 10-day limitation.

(2) A ruling by Attorney General Saxbe that local relief authorities are obligated by statute to provide AFA recipients with supplemental medical and hospital care.

(3) Activation of an interdepartmental committee named by the Governor to study programs dealing with problems of Ohio's aged.

(4) Issuance by the Division of regulations relating to the provision of drugs and medical requisites for AFA recipients.

EXPLANATION OF CHANGES

The Governor's order relaxing the 10-day restriction for the benefit of hardship cases also provided that physicians will be paid mileage of 10 cents a mile both ways for calls outside of corporation limits to places of residence only. Mileage for physicians had been eliminated under restrictions imposed July 1.

"Hardship" cases are those patients who, because of medical or surgical illnesses or disabilities, are in need of definitive therapy requiring the facilities of a hospital for its administration for a period longer than 10 days.

"Hardship" cases do not include convalescent patients retained in the hospital for convenience in providing convalescent care, nor those patients who are fit to be discharged from the hospital but for whom no place can be found to which they can be sent.

In the OSMAgram, dated October 9, it was erroneously stated that hardship cases also included those lacking a suitable residence upon leaving the hospital. Actually, patients must be discharged whenever the physician states that the patient can safely, medically speaking, leave the hospital.

Payment for hospital care will terminate on the date the doctor states the patient can be medically discharged regardless of the date of actual discharge from the hospital.

The special provision for hardship cases and the restoration of mileage are being tested for a three-month period ending December 31.

In placing the responsibility for supplemental care in the hands of local relief officials, Mr. Saxbe ruled that such responsibility is statutory, and obligates the local officials to assist if state Aid for the Aged assistance is inadequate.

COMMITTEE'S GOALS

The Governor's interdepartmental committee, created to coordinate activities of various state departments, pertaining to problems of the aged, has as its specific goals the provision of:

1. Proper medical care, including facilities and treatment for the mentally ill or physically disabled.
2. Equal work opportunities.
3. Adequate minimum incomes.
4. A decent home life, or, when such is not possible, proper and home-like institutional care.
5. Opportunities for participation in community activities.
6. Social services designed to aid in planning for retirement and meeting crises of later years.
7. Research and professional training on the human aspects of aging.

Those goals were fixed by the governor as he named the committee.

PERSONNEL OF COMMITTEE

Its membership includes: Mrs. R. I. Ireland, state welfare director, chairman; Dr. Robert Haines, mental hygiene and corrections director; Dr. Ralph E. Dwork, state health director; Dr. E. E. Holt, state superintendent of public instruction; Hugh D. Wait, industrial relations director; James Tichenour, Bureau of Unemployment administrator; Leland Dougan, Ohio Civil Service Commission, and James L. Young, Bureau of Workmen's Compensation administrator. Executive director of the committee is Charles Wheeler of the Ohio Legislative Service Commission staff.

PROVISION FOR DRUGS AND MEDICAL REQUISITES

Information regarding the revised program for providing drugs and medical requisites to recipients of aid for the aged under the Health Care Program of the Division of Aid for the Aged has been sent to Ohio druggists and to AFA subdivision offices.

The program restricts payment by the Division to druggists who affiliate themselves with the drug program by agreeing to accept a price schedule identical with that of the Veterans Ad-

ministration and the quality and quantity standards and procedures established by the Division.

The "Standards and Procedures for Dispensing Drugs and Medical Requisites," reading as follows, contain information which will enable physicians to cooperate with druggists by writing prescriptions in conformity with the standards, so this article should be clipped and saved for reference:

STANDARDS AND PROCEDURES FOR DISPENSING DRUGS AND MEDICAL REQUISITIES

1. **Policy on Provision of Drugs and Medical Requisites:** Within limitations of appropriated funds, the Division of Aid for the Aged will pay for drugs and medical requisites prescribed or ordered by a physician or dentist for recipients of Aid as an essential medical need to be used in the treatment of illness, injury or disability. Such items are furnished by participating pharmacists in accordance with the Division's quality, quantity and cost standards. **The Division does not pay for drugs or medical requisites dispensed by physicians or dentists.**

2. **Eligible Patients:** Any person who is currently certified as a recipient of Aid for the Aged is eligible for payment for costs of essential drugs and medical requisites prescribed by a physician or dentist.

3. **Participating Pharmacists:** Payment for drugs and medical requisites will be limited to those pharmacists who affiliate themselves with this program by accepting the "Agreement with Vendors of Drugs and Medical Requisites."

4. **Quality Standards:** Drugs meet quality standards if they have been clinically tested, approved and accepted by the Council on Drugs of the American Medical Association. Division policy provides that, in so far as possible, first consideration be given to drugs listed in the *U.S. Pharmacopeia*, *National Formulary*, and *New and Non-Official Remedies* in preference to more expensive special and proprietary drugs.

5. **Quantity Standards:** Quantity standards provide that the amount of drugs dispensed or prescribed is not to exceed a 30-day supply and is furnished on the basis of a prescription dated no more than one month prior to the date the prescription is submitted for filling (except when the original prescription has been refilled as expressly ordered by the physician or dentist). No prescription will be refilled more than three times nor for more than three months from the original date of the prescription. This time limitation is to assure that patients with chronic conditions will be seen by a physician at least once every three months.

6. **Cost Standards:** a. **Prescriptions** shall be priced in accordance with the Veterans Administration price schedule which has been accepted by pharmacies participating in the Veterans Administration program throughout the State.

b. **Medicine Cabinet Supplies.** The monthly subsistence payment to recipients includes an allowance for medicine cabinet supplies and **these items, consequently, are not to be ordered on prescription.** Medicine cabinet supplies include normal amounts of first-aid materials such as gauze, band-aids, adhesive tape, bandages, cotton and small amounts of antiseptics; common cathartics; mouth washes and gargles; common ointments and lotions; and common analgesics. **Only when items mentioned above are required for therapy of specific conditions being treated currently by a physician may they be ordered by a prescription to be paid for by the Division. Such prescriptions must be accompanied by a statement from the attending physician justifying the need for the items prescribed.** Payment for medicine cabinet supplies (when authorized) will be made at the wholesale price plus 66 per cent or the over-counter price, whichever is less.

c. **Medical Requisites** or sickroom supplies ordered by a physician for use in a recipient's home, including such items as fountain syringes, bedpans and urinals, invalid rings, hypodermic syringes and needles, icebags and caps, hot water bottles, electric pads, atomizers and nebulizers, shall be priced at the wholesale price plue 66 per cent or the prevailing over-counter price, whichever is less.

d. **Limitations on Payments.**

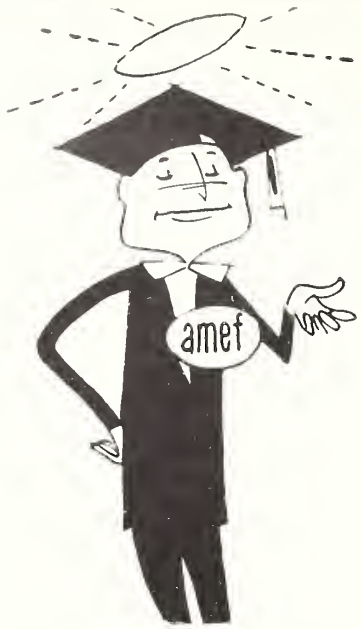
(1) **Any one prescription or medical requisite costing over $10.00 will require prior approval and shall be referred by the Subdivision Office to the Medical Director in Central Office.**

(2) The Pharmacist will not bill the Division for purchases of $2.00 or less but will collect directly from the recipient and give him a receipt for the purchase payment.

(3) **Recipients requiring purchase of a drug for a chronic condition (such as insulin for diabetes) will be given an allowance in their monthly money grant for this purpose when possible, and will pay the pharmacist for the drug at the time of purchase.**

e. **Nursing Home Supplies.** In general, it is expected that the monthly payment for care of a recipient in a nursing home will include the cost of items listed above under Medicine Cabinet Supplies and Medical Requisites. **Only those drugs and supplies that are needed to treat intercurrent illnesses or injuries or unusual conditions not customarily cared for in nursing homes will be approved for payment by the Division upon receipt of a statement from the attending physician justifying the need for the items prescribed.** Payment for authorized items will be made as stated in paragraphs 6a and 6b.

7. **Vitamins:** Payment will be authorized for vitamins only when they are prescribed as a specific remedy for a clinical avitaminosis. Since an adequate vitamin and iron intake can be



support medical education!

Every practicing physician has heard the appeal of the medical schools for desperately needed financial support.

The American Medical Education Foundation has an annual quota of $2,000,000 to be subscribed by practicing physicians.

Considering direct gifts, contributions through their Alma Mater and Alumni Committees and through the American Medical Education Foundation, this 2 million dollars has been greatly exceeded.

But time flies — the need is immediate — so this is another appeal for your immediate contribution either through your Alumni Committee Secretary or direct to the American Medical Education Foundation.

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Chicago 10, Ill.

obtained through a well planned diet, vitamins prescribed as a supplement to an individual's diet or as a tonic cannot be approved for payment. **Prescriptions for vitamins must state the specific clinical avitaminosis for which the vitamin is being prescribed.** The pharmacist will include this information in the copy of the prescription on his bill submitted to the Division for payment.

8. **Prohibited Payments:** Division of Aid for the Aged cannot pay for drugs provided to inpatients during their hospitalization nor to patients attending the outpatient clinic of a hospital when the cost of such medications is customarily included in the outpatient clinic fee per visit. **The Division cannot authorize payment for liquor in any form.** The fact that liquor may be prescribed for medicinal purposes by an attending physician does not in any way alter this policy.

9. **Procedure for Requesting Payment:** a. The recipient-patient takes a written prescription or order from his attending physician or dentist to a participating pharmacist of his choice.

b. The patient identifies himself as a recipient of Aid for the Aged and the pharmacist fills the prescription or order. The pharmacist may confirm that the purchaser is a recipient of Aid for the Aged by contacting the Subdivision Office.

c. For any prescription or medical requisite costing over $10.00 the pharmacist will obtain prior approval from the Medical Director, Division of Aid for the Aged, either directly or through the Subdivision Office.

d. If the cost of a purchase is $2.00 or less, the pharmacist will collect from the purchaser giving him a receipt for the purchase payment. If the cost of the purchase is $2.01 or more, the pharmacist may bill the Division unless the recipient pays for the drugs or medical requisites at time of purchase.

e. At the end of each month, or more often if he wishes, the pharmacist completes form AFA 508 "Bill for Drugs and Medical Requisites Dispensed by Pharmacist" for each recipient he has served and forwards the signed original and two copies to the Subdivision Office, Division of Aid for the Aged, of the county in which the recipient lives. All bills for drugs and medical requisites dispensed during a given month are due no later than the tenth calendar day of the month immediately following. Bills presented over 90 days after the date of sale will not be approved for payment.

Board Examinations

The Part I examinations of the American Board of Obstetrics and Gynecology are to be held in various parts of the U. S. and Canada on January 2. Details may be obtained from the secretary: Robert L. Faulkner, M. D., American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6.

Annual Meeting Program Schedule . . .

Plans Materializing Rapidly for 1958 Session in Cincinnati on April 15, 16 and 17; House of Delegates Opening Session, April 14

DETAILED planning was proceeding at a lively clip on the 1958 Annual Meeting program as this issue of *The Journal* went to press.

Physical arrangements for the meeting on Tuesday, Wednesday and Thursday, April 15, 16 and 17, in Cincinnati, have been worked out with the Netherland Hilton Hotel. Unless there are last-minute changes, all sessions of the Annual Meeting will be under one roof—the Netherland Hilton. Although the meeting will not officially open until Tuesday, April 15, the House of Delegates will hold its first meeting on April 14.

Officers of the sections are progressing in drafting their programs. A number of the sections are sponsoring joint sessions.

EXHIBITS NEEDED

The Committee on Scientific Work is working on the general session programs and the Committee on Scientific and Educational Exhibits is combing the state for exhibits. An application blank for space in the Scientific and Educational Exhibit appears elsewhere in this issue of *The Journal*. Invitations have been sent to prospective Technical Exhibitors. Space will be sold and assigned on a priority basis because of limited space in Cincinnati.

Monday, April 14, has been set aside as the day when the specialty societies and the various voluntary health associations can hold their meetings. Following is a skeleton outline of the 1958 Annual Meeting schedule:

MONDAY, APRIL 14

6:00 P. M.

Dinner Session, House of Delegates; Business Session.

TUESDAY, APRIL 15

8:30 A. M.

Registration Opens.

9:00 A. M.

Opening of Exhibits.

9:30 to 11:00 A. M.

Section Meetings.
- Anesthesiology and Otorhinolaryngology (combined session)
- Industrial Medicine
- Obstetrics and Gynecology
- Pediatrics and Radiology (combined session)
- Urology

11:00 to 11:30 A. M.

Recess for Tour of Exhibits.

11:30 A. M. to 12:30 P. M.

Section Meetings.
(Continuation of section sessions listed above.)

2:00 to 3:00 P. M.

General Session.
Panel Discussion, "Running Your Office."

3:00 to 3:30 P. M.

Recess for Tour of Exhibits.

3:30 to 5:00 P. M.

General Session.
Symposium on "Fractures."

WEDNESDAY, APRIL 16

8:30 A. M.

Registration.

9:00 A. M.

Tour of Exhibits.

9:30 to 11:00 A. M.

Section Meetings.
- General Practice, Internal Medicine, Radiology, Surgery (combined session)
- Nervous and Mental Diseases and Physical Medicine (combined session)
- Neurological Surgery
- Ophthalmology
- Workshop on Medical Writing

11:00 to 11:30 A. M.

Recess for Tour of Exhibits.

11:30 A. M. to 12:30 P. M.

Section Meetings.
(Continuation of section sessions listed above.)

2:00 to 3:00 P. M.

General Session.
- Address: F. J. L. Blasingame, new general manager, American Medical Association
- Film: "The Doctor Defendant," second in series of AMA films on physicians and their relationships with the courts.

3:00 to 3:30 P. M.

Recess for Tour of Exhibits.

3:30 to 5:00 P. M.

General Session.
Addresses by three guest speakers.

7:30 P. M.

Annual Banquet.

(Continued on Page 1326)

THURSDAY, APRIL 17

8:00 A.M.

House of Delegates Breakfast and Business Session

8:30 A.M.

Registration.

9:00 A.M.

Tour of Exhibits.

10:00 to 11:00 A.M.

General Session.

Panel discussion, "Treatment of Common Dermatological Problems."

11:00 to 11:30 A.M.

Tour of Exhibits.

11:30 A.M. to 12:30 P.M.

General Session.

Symposium, "What's New?" (Six 10-minute presentations on various areas of medicine, setting forth new developments, new treatment, new drugs, etc.)

2:00 to 3:30 P.M.

General Session.

Panel discussion, "The Acute Abdomen."

3:30 P.M.

Adjournment.

Fort Steuben Academy

"The Early Diagnosis of Bronchiogenic Carcinoma," was the subject discussed at the October 8 meeting of the Ft. Steuben Academy of Medicine. Speakers were Dr. Edmund Kent, head thoracic surgeon, University Medical Center, Pittsburgh, and Dr. John L. Quinn, surgical staff of Ohio Valley Hospital, Steubenville. The dinner meting was held at the Fort Steuben Hotel, Steubenville. This year's programs of the Ft. Steuben Academy have been approved as Category I by the American Academy of General Practice, each meeting giving one hour credit, officers announced.

Board Suspends Geer's License

On October 8, the State Medical Board suspended for an indefinite period the license of Dr. Joseph A. Geer, Lancaster, former Fairfield County coroner, effective November 1, 1957. Dr. Geer was placed on probation last Spring by the Mercer County Common Pleas Court, following his plea of guilty to a charge of falsifying 13 narcotics prescriptions. Subsequently, he resigned as coroner and he was expelled from membership in the Fairfield County Medical Society and from the staff of the Lancaster-Fairfield County Hospital.

Serious Penicillin Reactions Increasing, FDA Reports

Reporting on a nationwide survey of more than four years, Food and Drug Administration physician told the Fifth Annual Symposium on Antibiotics that the number of serious reactions to penicillin has been increasing annually. Dr. Henry Welch, chief of the FDA division of antibiotics, made the report.

Since 1945, Dr. Welch said, isolated reports of penicillin reactions with a relatively high percentage of fatalities have been appearing in medical literature. The survey, covering the principal antibiotics, showed a substantially higher number of reactions to penicillin than to other antibiotics.

In the survey, 3,419 case histories of severe reactions were classified, but 424 were excluded because of insufficient data. One third of the reported reactions to all antibiotics were classified as life-threatening and about nine-tenths of them were attributed to penicillin.

"The trend of increase in serious reactions, especially from penicillin given by intramuscular injection," the FDA says, "shows there should be a clear-cut indication of need before the drug is administered. The study of case histories indicates that there has not been indiscriminate use of penicillin by physicians." At one point Dr. Welch points out that the number of reactions to penicillin is still small when considering that millions of persons receive it each year and that it has saved tens of thousands of lives. He said the increased incidence of reactions is to be expected in the wise use of a highly antigenic substance.

In connection with the symposium, a group of physicians and pharmacologists discussed a new product that was described as an antidote to penicillin poisoning.

Eighth District Program at Marietta Well Attended by Profession

The Marietta Times devoted three columns of type with illustrations to the Eighth Councilor District Fall Postgraduate Program held at the Marietta Country Club on October 3. Approximately 75 doctors attended.

The scientific program was staged by a team from the Cleveland Clinic consisting of Dr. George Crile, Jr., Dr. Harriet Dustan and Dr. A. W. Humphries.

Representatives from the State Association were Dr. Robert Martin, Zanesville, OSMA President; Dr. George A. Woodhouse, Pleasant Hill, President-Elect, and Mr. Charles S. Nelson, Columbus, Executive Secretary. Dr. William D. Monger, Lancaster, Eighth District Councilor, took part in the proceedings. Dr. Deane H. Northrup, Marietta, president of the host Washington County Medical Society, headed the committee that staged the affair.

APPLICATION

For Space in the Scientific and Educational Exhibit

1958 Annual Meeting • Ohio State Medical Association

NETHERLAND HILTON HOTEL, CINCINNATI, APRIL 15, 16, 17

Fill Out and Mail to:

Committee on Scientific and Educational Exhibits,
Ohio State Medical Association,
79 East State Street,
Columbus 15, Ohio

DEADLINE FOR APPLICATIONS . . FEBRUARY 15, 1958

1. Title of Exhibit: .....
2. Name(s) of Exhibitor(s): .....

   .....

   Institution (if desired): .....

   City .....
3. Description of Exhibit: .....
   (Attach 200 Word Description to this Blank)
4. Exhibit will consist of the following: **(Check Which)**

   Charts and Posters..... Photographs..... Drawings..... X-Rays.....

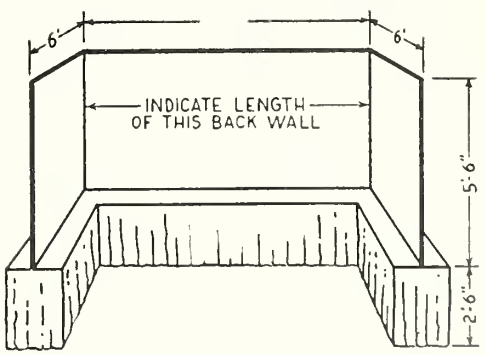
   Specimens..... Moulages..... Other Material .....
5. Booth Requirements:

   Length of back wall desired .....

   Minimum requirement .....

   Shelf desired (yes or no) .....

Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.



6. Do you want Association to provide view box..... or will you provide your own?.....
   OSMA will provide standard units; large size, 60 inches by 56 inches (inside measurements, 57 by 54); small size, 24 inches by 56 inches (inside measurements, 21 by 54). It is suggested that transparencies used should be no larger than 10 by 12 inches. All films should be in suitable mounts.

Principles of Obstetric Care . . .

Recommendations Compiled by Committee on Maternal Health After Extensive Study Approved by Council as Guides to Ohio Physicians

A SET of recommendations, entitled "Guiding Principles for Obstetric Care," which were compiled by the Committee on Maternal Health of the Ohio State Medical Association, were approved by The Council on September 14, 1957.

In doing so, The Council recommended that the principles be published in *The Journal* so that they would receive widespread publicity among the physicians of Ohio.

The principles, which were developed by the Committee on Maternal Health as a part of its study and evaluation of maternal deaths in Ohio since January, 1955, are as follows:

* * *

PREAMBLE

Adherence to well established and medically accepted principles of obstetrics is the foundation for good maternal health. However, the best of principles can achieve a goal only when applied diligently and intelligently. The Committee on Maternal Health of the Ohio State Medical Association, after extensive analysis and evaluation of maternal mortality data, has prepared and hereby recommends to all members of the medical profession the following principles:

PRENATAL CARE

Hemoglobin or hematocrit should be recorded at the first visit, and repeated at least in the seventh month on all patients. In those requiring treatment for anemia, the test should be repeated.

Blood should be tested for syphilis, and for blood grouping and for Rh factors at the first visit.

Blood pressure, weight, urinary albumin, and sugar should be recorded at every visit.

Visits should be required of all patients at least monthly in the first six months, every two weeks during the seventh and eighth month, and every week in the ninth month of pregnancy. In case of complications, especially toxemia, weekly visits should begin earlier (such patients should be seen two or three times a week or preferably hospitalized).

At the first visit, history should be obtained regarding previous pregnancies, menstruation (including date of last menstrual period and a carefully estimated date of confinement) and nephritis or any kidney ailment, hypertension, diabetes, scarlet fever, allergies, rheumatic fever or any form of heart disease, transfusions or previous surgery of the vagina or cervix.

Estimate of capacity of the pelvis should be made, including at least the diagonal conjugate and a realistic appraisal of the outlet.

A general physical examination, in addition to pelvic examination, heart and abdomen, also should carefully be made.

INTRAPARTUM AND POSTPARTUM CARE

On Admission to Maternity Hospital:

Qualified personnel should note the length of gestation, temperature, pulse and respirations, blood pressure and fetal heart rate, and should immediately report any abnormality to the attending physician. In active labor, determination of the blood pressure, pulse and fetal heart rate should be repeated at least hourly. Hematocrit should be done and catheterized urine should be examined on admission if clinically indicated.

The activity of labor, presence and amount of bloody show and state of membranes should be recorded and reported to the physician, together with Rh factors and serology data.

The time of last meal or ingested fluid should be called to the attention of the physician.

During Labor:

No street clothes should be worn in the delivery room—caps and masks are mandatory when the perineum is exposed.

Adequate observation by a nurse is necessary. One nurse may attend two or more patients.

A physician should be on the obstetric floor when a delivery is imminent. Medication by barbiturates, narcotics, scopolamine and adjuvant drugs always requires a physician's order and should be on an individual basis. Use of analgesics should be limited when nursing personnel is not adequate for bedside attendance.

Pituitary extract should **not** be given except on individual order, and then with extreme caution and with a physician in attendance.

No vaginal examination should be made on a patient who is in labor except under sterile conditions.

Rectal or vaginal examination should be made on a patient who is bleeding only when prepared for operative intervention both vaginally and abdominally. Blood and/or blood substitute should be available for immediate use.

Precipitate Delivery:

If precipitate delivery threatens, the head should not be held back by any method. Delivery of the head may be controlled by the attendant but never delayed. If controlled precipitate delivery occurs the blood pressure and pulse should be checked immediately and every five minutes for half an hour, the fundus held, and

the patient watched carefully for bleeding from hidden lacerations.

Anesthetic:

An anesthetic may be given only by a qualified person in accordance with the laws of the State of Ohio. A qualified person is a physician, or a nurse anesthetist who has completed an approved course of training in anesthesia and who works under the immediate supervision of a physician.

A general anesthetic (inhalation or intravenous type) should never be used if the patient has eaten within the past few hours. A general anesthetic should not be used unless it can be presumed that the patient's stomach is empty. Pituitrin should not be used if cyclopropane is administered. A spinal or caudal anesthetic should be given only by a physician familiar with the techniques and the problems. He must know how to obtain the proper level of anesthesia, and he must be prepared to treat the complications which may develop.

The anesthetist should be in constant personal attendance throughout the entire obstetrical or surgical procedure and should assist in the patient's care until she has recovered from anesthesia.

If local infiltration or pudendal block anesthesia is administered by the obstetrician, an anesthetist is not required. The obstetrician, however, must observe the patient for signs of toxic reaction to the local anesthetic drug, and be prepared to administer appropriate treatment if a reaction should develop.

Delivery:

The absolute minimum personnel includes obstetrician and circulating nurse and an anesthetist when a general anesthetic is used. Added nursing personnel should be within a moment's call for unforeseen emergencies.

Delivery through incompletely dilated cervix is extremely dangerous. High-forceps delivery should not be attempted. Version and extraction except for the second of twins is fraught with danger. Excessive fundal pressure is considered dangerous.

Consultation or assistance should be sought in cases entailing more difficulty than low-forceps delivery.

Asepsis should be surgically strict. Masks should be worn.

Excessive Crede maneuver is dangerous.

Postpartum: (the hazard of hemorrhage is highest now).

Careful visual examination of the cervix, vagina and delivered placenta should be made and manual examination of the uterus should be executed if indicated.

It is imperative that the firmness of the fundus and the extent of bleeding be carefully guarded for the first hour post partum. (Loss of 500 cc. or more is considered postpartum hemorrhage.)

If bleeding continues, the attending physician should check blood for clotting, start parenteral fluids or the transfusion and call for consultation.

Ample supplies of compatible blood must be readily available in the hospital, preferably on the delivery floor, twenty-four hours a day.

The vagina should never be packed for bleeding from above.

The Committee on Maternal Health has prepared these Guiding Principles after much deliberation and diligent study. They are sound, simple and clear-cut. The Committee is of the firm conviction that if these principles are utilized rigorously, there will be an appreciable reduction in maternal mortality and morbidity in Ohio.

In drafting these principles the Committee secured helpful ideas and suggestions from the following:

Massachusetts Medical Society Committee on Maternal Welfare: Minimum Standard of Obstetric Care. New England J. Med., 252:739-740, April 28, 1955.

Minimum Standard for Prenatal Care Recommended by Kings County Society Maternal Welfare Committee, Ohio State M. J., 32:762-763, August, 1936.

Now Is Time To Give TO AMEF

This Fall all Ohio physicians again have an opportunity to contribute to the American Medical Education Foundation.

A gift to AMEF or directly to the Alumni Fund of your own school is evidence of your belief that the Nation's medical schools can be financed through voluntary effort and that there is no need for Federal aid to meet the schools' operating budgets.

Donations to AMEF may be earmarked for your own school. They are tax-deductible.

Checks should be made payable to: American Medical Education Foundation. The address is: 535 N. Dearborn St., Chicago, Ill.

Kettering Hospital Dedicated In Loudonville

The new Kettering Hospital in Loudonville was dedicated on August 29 and present to participate in the ceremonies was Charles L. Kettering, renowned scientist, benefactor of the hospital, and a native of the community. Prominently mentioned during ceremonies for his work in laying the groundwork for the hospital was the late Dr. G. B. Fuller. Dr. Charles A. Doan, dean of the OSU College of Medicine, gave the principal address.

Sister Kenny Scholarship

The Sister Elizabeth Kenny Foundation has announced continuance of its post doctoral scholarships to promote work in the field of neuromuscular diseases. Details may be obtained from the foundation at 2400 Foshay Tower, Minneapolis 2, Minn.

Bills Before Congress . . .

Measures of Importance to Medical Profession Still in Hopper, Including Proposal to Add Health Insurance to OASI Program

MANY pieces of legislation of major importance to medicine, including two considered eminent threats to free medical practice, are to be considered by Congress when it convenes January 7.

The legislation consists of bills introduced in and carried over from the 1957 session. Further, it is not unexpected that the forthcoming session will bring in a large number of new health care bills.

It is of paramount importance that physicians familiarize themselves with two bills in particular, namely, the Forand bill (HR 9467) and the Kean bill (HR 8883).

THE FORAND BILL

Forand's bill has the support of such influential persons as AFL-CIO President Tom Meany. It would amend the Social Security Act to (1) initiate hospital and nursing care and surgical payments for persons eligible for retirement or survivorship benefits under OASI; (2) increase earnings formula to tax the first $6,000 of a person's income (instead of the present $4,200 ceiling), and (3) increase dollar benefits payable to workers, their dependents and survivors.

The bill would increase the OASI tax rate a half per cent on employees and employers alike, and three-fourths of one per cent on the self-employed under OASI. By 1975 the tax rate for employees would be 4.75 per cent, a like rate for employers for a total of 9.5 per cent of wages up to $6,000. The tax rate for self-employed would be 7.125 per cent, and maximum payment would be $427.50 a year.

Included in the proposed medical benefits are cost of semi-private hospital care for 60 days of any year and 120 days of nursing home care in any year.

LIMITS CHOICE OF DOCTOR

The bill also would finance the cost of necessary surgery (not elective surgery), provided that the surgeon selected by the beneficiary is certified by the American Board of Surgery or is a member of the American College of Surgeons (except in cases of emergency). For oral surgery, the patient would be allowed to select a duly licensed dentist of his choice.

Physicians would be paid fees prescribed by the Secretary of Health, Education and Welfare, and participating hospitals would be required to enter into an agreement for payment with the government.

THE KEAN BILL

The Kean bill would, among other things, provide compulsory Social Security coverage for physicians, benefits for dependents of disabled workers, payment for rehabilitation services, and increased benefits for workers who delay retirement.

It would raise maximum family benefits from the present $200 a month to $271.25. It would raise the total amount of wages subject to tax from the present $4,200 annually to $4,800. After 1975, a self-employed physician at the scheduled rates (6.375 per cent) would pay annually to the OASI trust fund $306.

Several other bills introduced provide different approaches to the same benefits.

OTHER BILLS

Other pending bills physicians should watch when the 1958 session convenes include:

Compulsory Health Insurance (S. 844, H. R. 3764)—A 1957 version of the old and rejected national compulsory health insurance measures of 1948, the sponsors being Senator Murray (D., Mont.) and Rep. John Dingell, Jr. (D., Mich.).

Federal Workers Health Insurance (S. 2339 and others)—Provide for a voluntary contributory health insurance program for federal employees and their dependents, both basic and major medical coverage.

Overseas Federal Medical Care (H.R. 6141)—Provides health and medical services for U. S. civilians overseas who are employed in government jobs, and also would cover their dependents.

Federal Medical School Aid (H.R. 6874)—Authorizes federal grants to medical schools and research facilities for construction of classrooms and laboratories for teaching.

Federal Loans to Hospitals (H.R. 1979)—For those hospitals interested in construction loans rather than Hill-Burton grants, these bills would authorize long-term government loans.

Reinsurance (S. 1750 and H.R.6506)—Permit pooling by various insurance companies without regard to the anti-trust laws for purpose of encouraging new experiments in health insurance coverage.

Aid for the Aged (H.R. 383 and others—Authorize grants for studies and projects for the aged.

Federal Advisory Health Council (H.R. 2435 and others)—Establish a Federal Advisory Council on Health, as recommended by the Hoover Commission.

Labeling for Household Use (H. R. 7388 and others)—Regulate the labeling of hazardous substances intended for household use.

Speed-Up in Payment of Workmen's Compensation Medical Bills Planned; Send to BWC Your Ohio License Number for Coding

EVERY Ohio physician who has been treating patients involved in industrial injury cases has received a written request from the Bureau of Workmen's Compensation to furnish it with the number of his State Medical Board license.

This information is needed by the Bureau in connection with its plans for speeding up the payment of medical fee bills through the mechanization of that phase of its activity. James L. Young, Administrator of BWC, is responsible for this innovation.

Under the new system, each claim will be indexed as presently done by a claims examiner. The information on the claims form will be placed on a punch card. The balance of the processing of the claim will be almost completely automatic. Since punch equipment is being used, it will be necessary to identify physicians by a code. It is planned to use the physician's Ohio license number as his identification.

If there is a poor response to the Bureau's request for physicians' license numbers, it will probably have to abandon the license number idea for identification and assign code numbers arbitrarily. This would require the Bureau to code each claim upon its receipt. If the license numbers are used and the physician places his license number on his fee bill, the coding will have been done and the processing will be much faster, according to Mr. Young.

Business machine equipment necessary for the new system is scheduled for delivery momentarily. It is hoped to have the system in effect yet this year.

In a communication to the Ohio State Medical Association, requesting the cooperation of physicians by responding to the Bureau's request for license numbers, Mr. Young stated:

"We expect that the contemplated system will make it possible for us to pay all approved medical obligations received in any four week period at the end of that period. We fully expect that this system will be a major improvement in compensation administration. Especially, it will create a prompt and efficient system for payment of our physicians as well as solving the major administrative bottleneck."

Ohioans Will Participate in "Grand Rounds" Telecast

Two Cleveland physicians will participate in a "grand rounds" telecast on coronary artery disease for American physicians on November 13. The telecast will be the sixth in the "grand rounds" series sponsored by The Upjohn Company.

Members of the panel, facing the cameras in New York, will include Dr. Claude S. Beck and Dr. Donald B. Effler, both of Cleveland. In Cleveland, a member of the Beck team will perform the so-called "Beck 1" revascularization procedure.

Closed-circuit program will be televised in 55 cities throughout the United States, including six cities in Ohio. Included on the program will be a transatlantic report from London and a visit to a research team in Italy.

Dr. Porterfield Gets Promotion in U. S. Public Health Service

Dr. John D. Porterfield, formerly director of the Ohio Department of Mental Hygiene and Correction, has been promoted to deputy surgeon general of the U. S. Public Health Service, making him second in command to Surgeon General Leroy E. Burney.

Dr. Porterfield left Ohio in October, 1956, to become one of four assistants to the surgeon general. He was raised in March, 1957, to assistant surgeon general and in September was named to the second highest post.

Dr. Porterfield held two important posts in Ohio. In 1947 he was named director of the Ohio State Health Department. In 1954 he became the first director of the newly created Ohio Department of Mental Hygiene and Correction.

Health Commissioners Meet . . .

OSMA President Urges Closer Understanding Between Private Practice And Public Health; Resolutions Stress Public Health Recommendations

IT is important to medicine that there be better understanding between public health practitioners and private practitioners, OSMA President Robert S. Martin told Ohio's health commissioners at their 36th annual conference in Columbus September 18-20.

Delivering the traditional OSMA president's address before the conference, President Martin told his audience that just as there is a need for better understanding of the private practitioner's problems on the part of public health, so is there need for private medicine to enlarge its understanding of public health practitioners.

Remarking that public health practice is in itself a medical specialty, Dr. Martin said there is definite need for both aspects of medicine, adding that "nobody can handle the whole thing."

The OSMA President told the commissioners that a progressive step toward achieving such understanding is for public health physicians to attend the meetings of their local medical societies, and to take an active interest in the societies' affairs. "In five or six counties, the health commissioner doesn't attend his local medical society meetings—and this is not good," Dr. Martin said.

He said the health commissioner who is active in his medical society develops an understanding and appreciation of private medicine's problems and policies and, at the same time, the commissioner has the opportunity to instill in the private practitioners an awareness and appreciation of the many problems facing public health today.

DR. DWORK REVIEWS YEAR

Members of the conference also heard a review of the past year of activities of the Ohio Department of Health, presented by Dr. Ralph E. Dwork, Ohio director of health.

Dr. Dwork's report contained the following highlights:

1. A warning that opinion that communicable disease is well on the way to being conquered is not accurate in the light of communicable disease incidence in the past 12 months.

2. Continued emphasis on staphylococcus investigations; 10 epidemics in nine Ohio counties were investigated during the past year.

3. Continued emphasis on total polio vaccination.

4. Emphasis on the penicillin program for rheumatic fever prophylaxis.

5. Recommendation for more emphasis on rabies control.

6. Reference to an investigation which has led to the conclusion that venereal disease incidence in Ohio is considerably higher than the reported incidence.

7. Recognizance of the completion of the clearance of tuberculosis case registers.

8. Recommendation that additional emphasis be placed on the field of chronic disease and the health of the aged.

9. Caution against poisoning from tolune diisocyanate used in Ohio industries producing urethane plastic.

Dr. Dwork also spoke at length concerning the anticipated influenza epidemic, and praised the OSMA Council for its interest in and cooperation with the Ohio Health Department in establishing policies concerning the expected epidemic.

RESOLUTIONS

Among resolutions passed by the health commissioners were the following:

1. That a committee be appointed to investigate and make recommendations concerning proposed efforts to obtain statutory fees on milk and meat inspection and a state wide code for regulation of milk and for meat sanitation.

2. Recommendation that the ODH, in cooperation with local health departments, increase its emphasis on nutritional programs, including problems of obesity, and that such programs be included in the school health program.

3. That the conference recommend some type of state regulatory control of bioanalytical laboratories and their technical personnel, such regulation not to include medical technologists or other technical personnel immediately responsible to or working under the direction and supervision of a pathologist, duly qualified doctor of medicine or doctor of osteopathy.

4. That the State Department of health investigate the feasibility of setting up a poison information and prevention center.

5. That the ODH continue to emphasize to physicians intramuscular penicillin prophylaxis for rheumatic fever as usually more effective than oral prophylaxis.

6. That the ODH assist local health departments to devise local registration of rheumatic fever patients for follow-up and assurance that penicillin prophylaxis is maintained.

7. That the ODH continue to seek state funds

to purchase polio vaccine for the biologics program; that the conference endorse the department's influenza vaccine program; that the ODH assist in initiating care functions in the field of chronic disease, and that the diabetes detection program be expanded.

8. That the ODH increase its activity in the field of chronic disease and aging, and that priority be given to provision of consultative and financial support of such local programs.

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

June 14—John W. Luttrull, Malvern, Indiana Univ.; John T. Rodgers, Marietta, Univ. of Pittsburgh; Jean C. Brierre, Columbus, Univ. of Montreal; Martin D. Keller, Columbus, Cornell Univ.;

August 27—Arnold Adicoff, Cleveland, Chicago Medical School; Donald K. Anderson, Cleveland, George Washington Univ.; Kenneth C. Archibald, Cleveland, Cornell Univ.;

Lee E. Bartholomew, Lima, Columbia Univ.; Donavin A. Baumgartner, Jr., Cleveland, Harvard Medical School; Robert M. Blizzard, Columbus, Northwestern Univ.; Robert E. Bolinske, Columbus, Marquette Univ.; Marcus B. Bond, Cincinnati, Washington Univ.; John D. Botti, Canton, Univ. of Pennsylvania; John M. Brand, Rush Medical College; William E. Brandt, Dayton, Indiana Univ.; Ian Hay Brown, Dayton, Univ. of Glasgow, Scotland; Ralph M. Brugger, Euclid, Univ. of Pennsylvania;

William R. Clements, Perrysburg, Tufts College; James J. Coviello, Cleveland, St. Louis Univ.; Thomas L. Crawford, Cleveland, St. Louis Univ.; Frank S. Cruickshank, Jr., Akron, Tufts Univ.; John H. Crump, Cincinnati, New York Medical College;

Bertram D. Dinman, Columbus, Temple Univ.; Frederick W. Dunlea, Youngstown, Georgetown Univ.; Maurice E. Dyer, Columbus, Cornell Univ.; Paul R. Ebling, Cincinnati, Univ. of Wisconsin;

Joseph D. Franzoni, Cuyahoga Falls, George Washington Univ.; Frank S. French, Cleveland, Univ. of Rochester; Roger B. Goodfriend, Univ. of Liege, Belgium; Raymond Harkavy, Cleveland, Univ. of Wisconsin; Bert G. Hassler, Chillicothe, Univ. of Southern California; Thomas W. Holmes, Jr., Toledo, Univ. of Tennessee;

Robert I. Jaslow, Jefferson Medical College; Robert H. Jebsen, Columbus, New York State Univ.; Edward F. Jones, Cleveland, Univ. of Oklahoma; Gordon C. Jones, Dayton, Indiana Univ.; Alfred M. Keirle, Cincinnati, Cornell Univ.; Harold E. Kelch, Lancaster, Washington Univ.;

Donald R. Lantz, Cuyahoga Falls, Medical College of Virginia; James J. Lehmann, Dayton, St. Louis Univ.; Janus C. Lindner, Cincinnati, Yale Univ.; Thomas L. Linn, Cincinnati, Univ. of Glasgow, Scotland; Erich H. Loewy, Cleveland, State Univ. of New York;

Lester W. Martin, Cincinnati, Harvard Medical School;James J. McDuffie, Dayton, Howard Univ.; Carolyn B. H. Montier, Cleveland, Howard Univ.; Leon M. Osachuk, Boston Univ.; Robert Oseasohn, Cleveland Hts., Long Island College;

Axel A. Paas, Univ. of Basel, Switzerland; Frank R. Patton, Oxford, Univ. of Illinois; Clinton R. Potts, Columbus, Univ. of Louisville; Donald L. Puzynski, Cleveland, Stritch School of Medicine of Loyola Univ.;

Robert P. Riley, Cleveland, St. Louis Univ.; Leonard P. Rome, Cleveland, Tufts University; Oscar J. Rosenzweig, Univ. of Szeged, Hungary; Robert M. Ross, Jr., Celina; McGill Univ.;

Robert E. Schulz, Wooster, Jefferson Medical College; Otto P. Schumacher, Cleveland, Johns Hopkins Univ.; Melvin Shafron, Cleveland, Harvard Medical School; William H. Shapiro, Youngstown, Chicago Medical School; Sanford A. Shmerling, Cleveland, Medical College of Georgia; Louis Simonson, Cleveland, Univ. of Leiden, Netherlands; Lowell J. Smythe, Middletown; Univ. of Wisconsin; Richard L. Sogg, Cleveland, Harvard Medical School; William I. Staples, Cleveland, State Univ. of New York; Robert L. Stuber, Marion, St. Louis Univ.; Danny D. Swihart, Troy, Indiana Univ.;

Robert L. Tyson, Cleveland, Columbia Univ.; Michael G. Weidner, Jr., Cleveland, Vanderbilt Univ.; Vernon E. Wendt, Cleveland, Columbia Univ.; Ferdinand Werner, Jr., Cincinnati, Univ. of Pennsylvania; Donald R. Weymann, Akron, State Univ. of New York; Ralph G. Wieland, Jr., Cleveland, Univ. of Pennsylvania; Robert L. Wright, Cleveland, Univ. of Maryland; John R. Yoder, Bellevue, Univ. of Rochester.

Jenkins-Keogh Proposals

In its December issue, *The Journal* will publish a detailed story regarding the Jenkins-Keogh proposals to allow self-employed persons deferred income tax payments on a portion of their earnings used to pay premiums for retirement insurance. Watch for it; then contact your Congressman, requesting him to support the proposals, H. R. 9 and H. R. 10.

Chest Essay Contest

The American College of Chest Physicians, 112 E. Chestnut St., Chicago 11, has announced its 1958 prize essay contest for undergraduate medical students. Contest closes April 15, 1958. Prizes are $500, $300 and $200.

In Memoriam . . .

Tilden J. Beck, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1901; aged 81; died September 11; member of the Ohio State Medical Association and the American Medical Association. Dr. Beck was honored by the Academy of Medicine of Cincinnati in 1951 for 50 years of service in the medical profession. Most of his practice was in the Bond Hill area. He was active in civic affairs of the community; was a member of the Presbyterian Church, and a veteran of the Spanish-American War. Survivors include his widow, two daughters and a step-son.

Arthur King Buell, M. D., Columbus; Ohio State University College of Medicine, 1915; aged 71; died October 13; member of the Ohio State Medical Association and the American Medical Association. Dr. Buell began his practice in Canal Winchester and moved to Columbus in 1918 where he practiced until his retirement in 1951. He was active in a number of organizations, including the Elks Lodge, Odd Fellows, Knights of Pythias, Columbus Athletic Club, Scioto Country Club and several Masonic bodies. Surviving are his widow, two daughters, two sisters and a brother.

Herman Karl Dimlich, M. D., Cleveland Heights; Hahnemann Medical College and Hospital of Philadelphia, 1921; aged 59; died September 17; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; member of the Cleveland Surgical Society. Dr. Dimlich practiced in Scranton, Pa., until 1936 when he moved to Cleveland to continue his practice there. Dr. Dimlich was president of the State Medical Board. He was first appointed to the board in 1955 and became president in 1956. Surviving are his widow, two sons, a daughter and a brother.

Robert S. Dinsmore, M. D., Cleveland; Washington University School of Medicine, St. Louis, 1917; aged 65; died September 24; member of the Ohio State Medical Association, the American Medical Association; Fellow of the American College of Surgeons; member of Southern Surgical Association; Eastern Surgical Society, the American Goiter Association, the American Association of Railway Surgeons; past-president of the Academy of Medicine of Cleveland; former chairman of the Section on Surgery of the AMA; past-president of the American Surgical Association; diplomate and member of the board of directors of the American Board of Surgery. Dr. Dinsmore served his entire medical career in Cleveland. His first association there was at Lakeside Hospital, first as an intern and later as resident in surgery. He joined the staff of the Cleveland Clinic Foundation in 1924. In 1949 he was made chief of the Department of General Surgery, a post which he held until 1956 when he was named senior consultant in the department. Other affiliations included memberships in Delta Tau Delta, Nu Sigma Nu, the Pasteur Club and the Medical Arts Club. He also was a trustee of the McGregor Home in Cleveland. His widow survives.

Louis Marsh Dolloway, M. D., Toledo; Georgetown University School of Medicine, 1900; aged 82; died September 21; member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award; member of the American Medical Association. Dr. Dolloway first began the practice of medicine in Toledo 57 years ago. He was a veteran of World War I, having served as a lieutenant in the Navy during that war. His widow survives.

Eugene B. Ferris, M. D., New York City; University of Virginia Department of Medicine, 1930; aged 52; died September 26; former member of the Ohio State Medical Association. Dr. Ferris was a former resident of Cincinnati and from 1935 to 1952 was on the faculty of the University of Cincinnati College of Medicine. He left Cincinnati and went to Atlanta, Ga., where for a time he was associated with the Grady Hospital there. His recent association was as medical director of the American Heart Association. He was affiliated with many professional organizations. Surviving are his widow, two daughters, a son and his mother.

Jerry M. Garber, M. D., Mansfield; Western Reserve University School of Medicine, 1895; aged 85; died September 30; member of Ohio State Medical Association, American Medical Association, and American Academy of Ophthalmology and Oto-Laryngology; Fellow of the American College of Surgeons. Dr. Garber practiced for 12 years in Plymouth before he moved to Mansfield, where he practiced his specialty after training in London and Vienna. He had been honored with the OSMA 50-Year Award. Affiliations included memberships in several Masonic bodies, the Elks Lodge and the Kiwanis Club. Surviving are his widow; a son, Dr. C. Zent Garber, of New York City; a daughter and a sister.

William E. Gernhard, M. D., Lakewood; University of Wooster, Medical Department, Cleveland, 1902; aged 78; died September 10; member of the Ohio State Medical Association. Dr. Gernhard practiced medicine in the west side of Greater Cleveland for 55 years, retiring only last May. An Army veteran, he had served as captain in the Medical Corps during World War I. Affiliations included membership in the Masonic Lodge. Surviving are his widow, a son and two daughters.

Willis H. Hodges, Sr., Columbus; Ohio State University of Medicine, 1912; aged 71; died September 28; member of the Ohio State Medi-

cal Association. Dr. Hodges practiced medicine for 44 years in Columbus. He was a veteran of World War I, a member of the Community Church, the Masonic Lodge, Nu Sigma Nu and Phi Gamma Delta. Surviving are his widow and a son, Dr. Willis H. Hodges, Jr., also of Columbus.

John Hutchfield, M. D., Columbus; Ohio Medical University, Columbus, 1897; aged 86; died September 21; former member of the Ohio State Medical Association. Dr. Hutchfield was a practicing physician over a period of more than a half century. He began practice in Moxahala, Perry County, but moved to Columbus after five years there. Surviving are his widow; two daughters, one of whom is Dr. Thelma H. Potts, of San Mateo, Calif.; also a brother.

John A. Judy, M. D., Oneco, Fla.; Washington University School of Medicine, 1915; aged 69; died September 23; member of the Ohio State Medical Association, the American Medical Association, the American Academy of Orthopedic Surgeons; Fellow of the American College of Surgeons; diplomate of the American Board of Orthopedic Surgery. Dr. Judy moved to Dayton in 1926 for orthopedic work at the Barney Community Center under sponsorship of Harvard University. He decided to stay and practiced there until 1954 when he moved to Florida. He continued until recent months to make periodic visits to the convalescent center. Dr. Judy was a veteran of World War I, having served in the Navy from 1917 to 1921. Surviving are his widow, a daughter, a sister and a brother.

Kenneth W. Keever, M. D., Magnetic Springs; Jefferson Medical College of Philadelphia, 1934; aged 51; died October 10; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Physical Medicine and Rehabilitation. Dr. Keever was founder and director of the Magnetic Springs Foundation. He gave up his practice in Richwood, studied physical medicine and rehabilitation for two years at the University of Pennsylvania and at Warm Springs, Ga., and founded the institution in 1955. Surviving are his widow, a daughter, a son and two brothers.

Daniel Casteel Keller, M. D., Cuyahoga Falls; St. Louis University School of Medicine, 1913; aged 77; died September 21; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Keller had been a practicing physician in Cuyahoga Falls for 44 years. He was a member of the Masonic Lodge, the Kiwanis Club and the Methodist Church. Surviving are two sons, one of whom is Dr. Bayard M. Keller, also of Cuyahoga Falls; two sisters and a brother.

Michael J. Kocialek, M. D., Poland, Mahoning County; Georgetown University School of Medicine, 1920; aged 60; died September 10; member of the Ohio State Medical Association, the American Medical Association, and the World Medical Association. Dr. Kocialek had been a practicing physician in the Greater Youngstown area for 36 years. He was a member of the St. Casimir Church, the Youngstown Chamber of Commerce, the Elks Lodge, Youngstown Club and the Congressional Country Club of Washington. Surviving are his widow, two daughters, a brother and two sisters.

Theron Harvard Morgan, M. D., Athens; George Washington University School of Medicine, 1929; aged 57; died October 5; member of the Ohio State Medical Association; Fellow of the American College of Surgeons. A native of Athens County, Dr. Morgan returned there and practiced for more than a quarter-century after completing residency training in Detroit. He was a member of Phi Chi, the Skyline Gun Club, and the Church of the Good Shepherd. Surviving are his widow, and a daughter.

Albert H. Rodenberg, M. D., Cincinnati; Eclectic Medical College, Cincinnati, 1923; aged 63; died September 30. Dr. Rodenberg served for 25 years with the Cincinnati Board of Health. He was a veteran of World War I and a member of the Masonic Lodge. Survivors include his widow and four daughters.

Edward G. Replogle, M. D., Los Angeles, Calif.; Indiana University School of Medicine, 1908; aged 73; died September 19. Dr. Replogle practiced for many years in Versailles in Darke County before he moved to California.

Arthur L. Stotter, M. D., Shaker Heights; Rush Medical College, 1917; aged 65; died September 11; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Ophthalmology and Oto-Laryngology; former chairman of the nose and throat section of the Academy of Medicine of Cleveland. Dr. Stotter practiced for nearly 40 years in the Cleveland Area. He was a veteran of World War I, having served as captain in the Army Medical Corps. Survivors include his widow, two daughters and a brother.

George F. Swan, M. D., Cambridge; Ohio State University College of Medicine, 1918; aged 68; died September 26; member of the Ohio State Medical Association, the American Medical Association, and Fellow of the American College of Surgeons. Dr. Swan was a former member of The Council of the Ohio State Medical Association, having served as Councilor for the Eighth District from 1939 to 1946. He was also a Past-President of the Guernsey County Medical Society, held other offices in the local society and served on numerous local committees. A native of Guernsey County, Dr. Swan returned to practice there following service as a medical officer in the Navy during World War I. For a number of years he operated the Swan Hospital in Cambridge in association with his late brother, Dr. Reo M. Swan,

who preceded him in death only last March. Dr. Swan was active in numerous community affairs; was a member of the board of Muskingum College and a director of the Cambridge Loan & Building Co. He was a member of several Masonic bodies, the American Legion, the Kiwanis Club and the Baptist Church. Survivors include his widow, a sister and a brother, Dr. John Raymond Swan of Indianapolis.

Henry L. Wenner, M. D., Elgin, Ill.; University of Michigan Medical School, 1914; aged 69; died September 21. Dr. Wenner practiced in Toledo in association with his father, the late Dr. H. L. Wenner. He moved from Toledo to Illinois in 1932. Survivors include his widow and three sons.

J. Glen Wilmore, M. D., Cleveland; University of Michigan Medical School, 1916; aged 68; died September 13; member of the Ohio State Medical Association and the American Medical Association. Dr. Wilmore was a native of Van Wert. Upon completion of his medical school training, he moved to Cleveland and had been a practicing physician there since. He was a 32nd degree Mason. Surviving are his widow, a son and a daughter.

Cleveland Medical Writer Honored With Blakeslee Award

Don Dunham, medical writer for the *Cleveland Press*, has again received national distinction for his work. Dunham's story on Cleveland Clinic's pioneering stopped-heart operation was unanimously selected as winner in the Blakeslee "spot news" category by the American Heart Association, sponsor of the award. Four other winners received similar awards. The story appeared in *The Press* April 16, 1956.

The award, which includes $500 in cash, was presented at a luncheon in New York Athletic Club on October 5.

Previous awards won by Dunham include the Lasker Award of 1950, given for his series, "Fluorides and Your Children." This series also won a top Cleveland Newspaper Guild award that year.

He was one of six nationally known science writers invited to participate in a series of conferences with New York physicians on medical-press relationships sponsored by the Josiah Macy Jr. Foundation.

The American Foundation for Allergic Diseases, 801 Second Ave., New York 17, has announced post-doctoral fellowships in research and clinical allergy. Candidates must be graduates of approved medical schools and must have completed one or two years of graduate training required as a preliminary to certification by the Board of Internal Medicine or Pediatrics.

Do You Know? . . .

Dr. Edward A. Gall, professor of pathology at the University of Cincinnati College of Medicine, was co-moderator of a one-day seminar during the meeting of the American Society of Clinical Pathologists in New Orleans. The subject was "Diseases of the Lymph Nodes and Spleen."

* * *

New associate professor of psychiatry in the University of Cincinnati College of Medicine is Dr. Roy M. Whitman, formerly chief of neurology and psychiatry at the Veterans Administration Research Hospital, Chicago, and Northwestern University faculty member.

* * *

Dr. Howard D. Fabing, Cincinnati, recently addressed the Royal Society of Medicine in London, England, on the subject, "Biochemistry and Schizophrenia," and attended sessions of the International Scientific Society in Zurich, Switzerland.

* * *

Dr. B. W. Abramson, Columbus, recently represented the American Psychosomatic Society as a delegate to the World Federation and Mental Health Congress in Copenhagen. His trip abroad included a 10-week tour of the Scandinavian Countries.

* * *

Dr. Robert S. Martin, Zanesville, President of the Ohio State Medical Association, recently addressed the Muskingum County Pharmaceutical Association.

* * *

Professor Joseph B. Homan, director of the University of Cincinnati College of Medicine department of medical art for 38 years, has been named a fellow of the Biological Photographic Association.

* * *

Dr. William G. Wasson, Canton, has been appointed physician and surgeon in charge of medical affairs for the Timken Roller Bearing Company's Canton and Gambrinus Divisions.

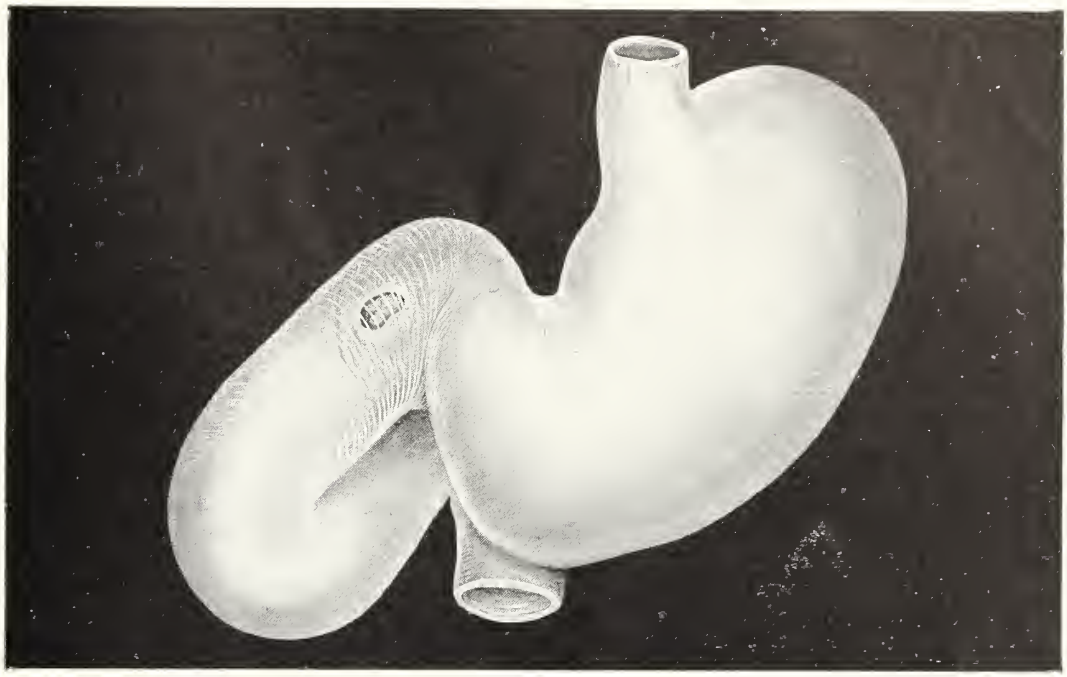
* * *

Dr. A. S. McCormick, Akron, was honored at recent dedication ceremonies for the new recovery room at Children's Hospital in Akron. The room was dedicated to Dr. McCormick for his more than 40 years of service to the hospital and to the community.

* * *

Two Ohio physicians were honored on September 27 at the annual meeting of the American Medical Writers' Association by being awarded Fellowships in the organization. They are Dr. Raymond C. Pogge, Cincinnati, director of medical research for the Wm. S. Merrill Company; and Dr. Jonathan Forman, Columbus, Editor of *The Journal*.

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Pro-Banthine® "proved almost invariably effective in the relief of ulcer pain,

*in depressing gastric secretory volume and in inhibiting gastrointestinal motility."**

"Our findings were documented by an intensive and personal observation of these patients over a 2-year period in private practice, and in two large hospital clinics with close supervision and satisfactory follow-up studies."*

Among the many clinical indications for Pro-Banthine (brand of propantheline bromide), peptic ulcer is primary. During treatment, Pro-Banthine has been shown repeatedly to be a most valuable agent when used in conjunction with diet, antacids and essential psychotherapy.

Therapeutic utility and effectiveness of Pro-Banthine in the treatment of peptic ulcer are repeatedly referred to in the recent medical literature.

Pro-Banthine Dosage

The average adult oral dosage of Pro-Banthine is one tablet (15 mg.) with meals and two tablets at bedtime.

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*Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthine in the Treatment of Peptic Ulcer. A Clinical Evaluation with Gastric Secretory, Motility and Gastroscopic Studies. Report of 60 Cases, Am. J. M. Sc. *232*:156 (Aug.) 1956.

SEARLE

Activities of County Societies . . .

First District

(COUNCILOR: FRANK H. MAYFIELD, M. D., CINCINNATI)

ADAMS

Dr. Frank H. Mayfield, Cincinnati, Councilor of the First District, was guest speaker at the October 23 meeting of the Adams County Medical Society in the office of the county health commissioners, Adams County Hospital. Dr. Mayfield discussed matters of interest to the medical profession. The annual business meeting was followed by luncheon.

CLERMONT

Dr. R. D. Carr was host to the Clermont County Medical Society on October 16. Program speaker was Dr. Vincent J. Seiwert, Cincinnati, who discussed "Diseases of the Thyroid."

HAMILTON

The Academy of Medicine of Cincinnati held two regular academy meetings in October.

On October 1 the subject, "Cancer of the Gall Bladder and Bile Ducts," was discussed by Dr. John McMaster Waugh, head of the Section on General Surgery, Mayo Clinic. It was a joint meeting with the Cancer Council.

On October 15 the subject of discussion was "Radiation Hazards in Diagnostic Roentgenology." The speaker was Dr. Russell H. Morgan, professor of radiology, Johns Hopkins University.

A coming meeting on November 19 will feature "Estate Planning for Doctors" in which several authorities in the investment field will participate.

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

CLARK

After a three-month recess, the Clark County Medical Society held its first 1957 autumn general meeting September 16 with 64 in attendance.

Among them was Dr. Frank Paul Anzinger, Sr., one of the Clark County Medical Society's 50-year members.

Guest speaker was Dr. William E. Hunt, assistant professor of neurosurgery at Ohio State University and chief of neurosurgery at White Cross Hospital, Columbus. Dr. Hunt's topic was "Evaluation of Headache."

Dr. John D. LeFevre, society president, announced that a poll of the members regarding continuation of the society's bulletin, a type of newsletter, was overwhelmingly in favor of the bulletin.

The Clark County Medical Society also bought 50 tickets to the Wittenberg College - University of Akron football game as part of a community drive to fill the local stadium for the opening game of the collegiate year in Springfield. Dr. Joseph Rinehart said he would underwrite the purchase and later reported all the tickets were sold.

In a discussion of Asian flu vaccine, Dr. Le Fevre reminded members it was a matter of judgment and conscience on the doctor's part regarding a fee for the vaccine. Because of this, the Society established no fee policy on the vaccine.

Two associate members were voted to active status at the meeting. They are Dr. Ernest Anderson and Dr. John Elliott.

Dr. John Sheets and Dr. John Titus were voted to associate membership.

Dr. E. H. Winterhoff served as program chairman for the meeting. He was assisted by Dr. Harold Fishbain, Dr. G. A. Smith, Dr. G. R. Horton and Dr. Samuel S. Leber.

Both Mercy and City Hospitals in Springfield have nine new interns this autumn. Interns at Mercy Hospital are Luke Combs, David J. Landon, C. Patrick Lewis, Walter B. Long, W. Starr Miller, Carl S. Ray, John W. Reichsteiner, James R. Stull and Richard L. Stump.

Interns at City Hospital include Hans Bergeest, William Deupree, Henry Eshelman, LeRoy Eulberg, Howard Faust, Gordon Leonard, Thomas Perkins, Clement Robbin, III, and Edwin Robert. —Tom Duross, Executive Secretary.

DARKE

The regular monthly dinner meeting of the Darke County Medical Society was held on October 15 in Greenville. Speaker was Dr. W. E. Johnson, whose subject was "Disorders of Feet in Children and Adults."

GREENE

The *Xenia Gazette* reported the September meeting as follows:

Members of the Greene County Medical Society held a discussion on the use of vaccine for Asian influenza when the group met at Greene Memorial Hospital.

The society recommends that persons desiring the vaccine should consult their own physicians concerning the use of it.

Dr. Stanley L. Block, associate professor of the University of Cincinnati College of Medicine, spoke on the subject, "Tranquilizers—A Clinical View."

The meeting was presided over by Dr. J. R. Schauer of Fairborn.

MIAMI

Doctor-Lawyer Professional Relations was the theme of the October 4 program of the Miami County Medical Society. Members of the Miami County Bar Association were guests for the meet-

ing at the Dettmer Hospital in Troy. Part of the program consisted of showing the film "The Doctor Defendant," a movie produced by the Wm. S. Merrell Company.

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

ALLEN

The Lima and Allen County Academy of Medicine met at the Shawnee Country Club for a dinner meeting on September 17. Guest speaker was Dr. Samuel Saslaw, of the Department of Internal Medicine, Ohio State University College of Medicine, whose subject was, "The Current Trend in Antibiotic Therapy."

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

SANDUSKY

A group of approximately 20 members of the Sandusky County Medical Society visited the Parke, Davis & Company pharmaceutical plant in Detroit, Mich., September 19 and 20.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNSTOWN)

MAHONING

The Mahoning County Medical Society inaugurated a new series of programs for medical assistants, the first meeting being held on October 3 in the Jade Room of the Mural Building in Youngstown. Dinner was followed by a program.

Speakers included Mrs. Dorothy Walls, executive secretary of the Youngstown Area Heart Association; Attorney Phillip A. Millstone, Betty Daichendt, and Dr. Andrew A. Detesco, president-elect of the Society.

The program was arranged by the Society's public relations committee headed by Dr. L. S. Shensa.

The Mahoning County Medical Society sponsored its Doctor's Medical Assistants Meeting on October 3 in the Mural Room of the VFW Building in Youngstown.

STARK

Lawyers, physicians and dentists "talked shop" at a meeting of more than 200 representative members of the three professions on September 25 in Mergus Restaurant, Canton. The meeting was arranged by the interprofessional committees of the three groups, the Stark County Medical Society, the Stark County Bar Association and the Stark County Dental Society. A film, "The Medical Witness," was shown as part of the program.

SUMMIT

Akron area citizens are invited for the third year to attend a series of Medical Forums co-

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Immediate opening for a full-time physician with the fastest growing major producer in the aluminum industry.

This is a challenging career opportunity for professional advancement within an expanding Industrial Health Program. Training and experience in occupational medicine or other clinical specialties preferred.

Duties include participating in study and control of the occupational environment. Well equipped dispensary in new plant on Ohio River between Parkersburg and Huntington.

Salary range and benefits adequate to attract top candidate.

Interested applicants send resumé including full details of education, experience, marital status, age, etc., and recent photograph to:

Medical Director

KAISER ALUMINUM & CHEMICAL CORPORATION

c/o Ravenswood, West Virginia

sponsored by the Summit County Medical Society. The series is being conducted in cooperation with the University of Akron and the *Akron Beacon-Journal.*

Topics for the forums are: October 25, "Mental Illness"; November 8, "Are You Allergic?"; and November 22, "Childbirth and Its Problems."

Coordinator of the forums is Dr. Keith C. Keeler, who is director of the Summit County Rehabilitation Center and a member of the Society's public relations committee.

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D., LANCASTER)

FAIRFIELD

The Fairfield County Medical Society laid final plans for its educational exhibit at the Fairfield County Fair. The exhibit, borrowed from the American Medical Association, is a public educational exhibit on bone and muscle structure of the human body. Members also agreed to help man a first aid booth established by the Fair Board.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

The first "Clinic Day" sponsored by the Columbus Academy of Medicine was very successful and drew an audience of approximately 270 members and guests. The program held on October 5 in the Veterans Memorial Building went according to the announced program with the exception of one guest speaker. Dr. Reed Nesbit, of the University of Michigan Medical School, was unable to be present. In his place, his assistant, Dr. Jack Lapides spoke on the subject of carcinoma of the prostate gland.

At the meeting Dr. Ollie M. Goodloe, who is leaving his post as Columbus health commissioner to accept a position out of state, was voted an honorary membership in the Academy.

For the fifth year, the Academy is sponsoring its Public Relations Institute for Medical Assistants on November 13. The program will begin at 4:30 p. m. in the Grandview Inn. At the evening banquet, Leo Brown, public relations director for the American Medical Association, will be special speaker.

On November 18 the Academy will hold its annual business meeting for nomination of officers, final approval of the revised by-laws, and special reports. The meeting will begin at 8 p. m. in the Columbus Art Gallery.

On December 7 the Academy will hold its annual banquet at the Columbus Athletic Club. Fifty-year members and living past-presidents will be honored at that time.

Cook County
Graduate School of Medicine

Announces

THE TWO-WEEK INTENSIVE COURSE IN SURGICAL TECHNIC

Starting dates: December 2, 1957; January 27, February 10, February 24, 1958, and other dates throughout the year.

An intensive and practical course which stresses the technic of the more common procedures in General Surgery. Lectures and demonstrations are presented each morning by members of the Attending Staff of Cook County Hospital. Postgraduate students participate in practice animal surgery each afternoon. Surgical Clinics are presented in the Operating Rooms of Cook County Hospital.

Surgical procedures covered in this program include: Surgery of Large and Small Bowel; Gastric Surgery; Surgery of Thyroid, Breast, Gallbladder and Hernia; Amputation; Appendectomy; Abdominal Wall Incisions; Anorectal Surgery.

Registrations limited for each course. For descriptive circulars and application forms address:

REGISTRAR, 707 South Wood Street, Chicago 12, Illinois



Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. C. H. Bell, 754 Dickson Parkway, Mansfield
(See Page 1233 for roster of officers.)

FALL CONFERENCE

The Fall Conference of the Woman's Auxiliary to the Ohio State Medical Association was held on September 17, at the Deshler-Hilton Hotel, Columbus. The county presidents, officers, chairmen and members-at-large and State Board members were served coffee and rolls during the hour of registration.

Mrs. V. R. Frederick, president, called the general meeting to order, greeted members and pointed out that at the Fall Conference the members would find fellowship, the answers to their questions, the inspiration for the year ahead, and the great satisfaction of planning to meet mutual objectives. Mrs. Frederick then presented Mrs. W. R. Gibson, president-elect who was in charge of the Conference. Mrs. Gibson explained the program for the day. The members adjourned to the various rooms for meetings with the state chairmen and officers. There were three sessions of discussion groups for instruction by the chairmen and an exchange of ideas by the members which enabled them to receive an over-all view of auxiliary work for the present year.

Luncheon was held in the Grand Ballroom with Mrs. V. R. Frederick presiding. Honored guests at the speakers table were Dr. Robert Martin, President of the Ohio State Medical Association; Mr. Charles S. Nelson, OSMA Executive Secretary; Mr. George H. Saville, OSMA Public Relations Director; State Officers; Mrs. Rivington Fisher, who was chairman of the Fall Conference meeting, and Mrs. Ollie M. Goodloe, president of the Franklin County Auxiliary.

Dr. Robert Martin was the speaker for the luncheon meeting and expressed his appreciation for the excellent work done by the Auxiliary. Following the luncheon a general discussion with questions and answers was held.

BUTLER COUNTY

The Woman's Auxiliary to the Butler County Medical Society held its Annual Silver Tea on September 24 at the home of Mrs. Donald Blizzard. Speaker for the afternoon was Mrs. Samuel L. Meltzer, Portsmouth, First Vice-President of the State Auxiliary. Mrs. Meltzer reported on the National Convention held in New York City and stated the four points to be stressed by the Auxiliary this year.

Mrs. William Patton, Mrs. Paul Woodward, Jr., Mrs. Harold Rothermel and Mrs. Jack Varney were welcomed as new members.

On the committee in charge of the tea were Mrs. Charles Atkinson, Chm., Mrs. John Carter, Mrs. Ross Hill, Mrs. Anthony Kokevahis, Mrs. Robert Wilson and Mrs. Stanley Weinstein.

CLARK COUNTY

The Woman's Auxiliary to the Clark County Medical Society entertained three state officials at its first fall meeting on September 26, at the home of Mrs. E. Paul Greenawalt. The special guests, who also attended the tea honoring new members following the organizational meeting, were Mrs. V. R. Frederick, State President, Mrs. M. J. Towle from Urbana and Mrs. H. J. Staten, Director of District 2 from Dayton.

Mrs. Robert A. McLemore, President, announced her committees for the year. Serving with Mrs. McLemore will be Mrs. W. H. Crays, President-Elect; Mrs. John A. Davidson, vice-president; Mrs. John Riesser, Rec. Sec'y.; Mrs. W. W. Robey, Cor. Sec'y.; and Mrs. Donal H. Guyton, treas.

Presiding at the tea table were Mrs. R. G. Boehme, Mrs. Charles Evans, Mrs. R. C. Hebble, Mrs. A. R. Kent and Mrs. M. S. Collins. Mrs. John A. Davidson was chairman for the affair.

COLUMBIANA COUNTY

Thirty members of the Woman's Auxiliary to the Columbiana County Medical Society met



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National Association of Private Psychiatric Hospitals
ACCREDITED: by the Joint Commission on Accreditation of Hospitals

September 24 for luncheon at the home of Mrs. Fred Jose in Damascus.

Mrs. Virgil Hart of Salem, president, presided at the business meeting. The nurse recruitment chairman, Mrs. R. V. Costello, of East Liverpool, reported that one student nurse scholarship had been awarded to a 1957 graduate of East Liverpool High School. There being no student nurse program in Salem at this time, the money allotted for that purpose was donated toward the expense of transferring their students.

The Auxiliary will support the four-point program of the State Organization. It was decided to continue the Student Nurse Scholarship Fund and the Geriatric program on local bases. The local Auxiliary received recognition by the appointment of its junior past-president as State Health chairman, Mrs. William Horger of East Liverpool.

CUYAHOGA COUNTY

Distribution of 10,000 Personal Health Information cards free of charge to residents of Cuyahoga County was launched by the Woman's Auxiliary of the Cleveland Academy of Medicine. The project was financed by the Academy.

The card, a wallet-sized medical history form, according to Mrs. Roscoe J. Kennedy, president, readily acquaints doctors with the name, address, family physician, allergies, blood type, and dates of immunizations, vaccinations, inoculations and operations of a citizen. Mrs. Myron M. Perlich has assisted Mrs. Kennedy in plans for distribution. Proof of the card's value was a total of 4000 requests for the first week of the campaign.

Mrs. C. A. Colombi recognized the value and need for these Personal Health Information cards when they were introduced at a session of the American Medical Association which she was attending in New York City in June.

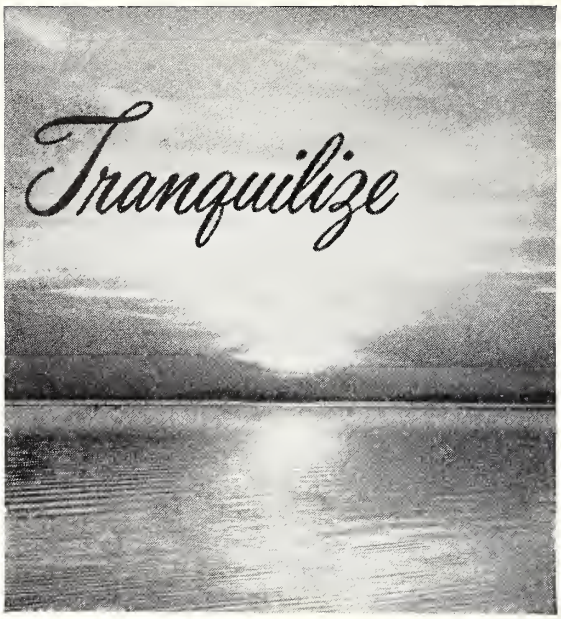
The Academy has received many congratulatory messages about the new service and PTA groups have shown enthusiasm with the possibility that the health cards may be adopted as part of the 1957-58 program.

The Auxiliary received a resolution from the Board of Education of the Cleveland City School District conveying its sincere appreciation for its cooperation in the Salk Polio Immunization Program in the Cleveland Public Schools.

ERIE COUNTY

The 10th anniversary program of the Woman's Auxiliary to the Erie County Medical Society, brought the organization to the threshold of its second decade of activity which accents community service. Mrs. Arthur Groscost was hostess for the meeting at her home on September 9.

The goals and ideals of the organization were emphasized by Mrs. W. P. Skirball, president, as she opened the meeting and introduced Mrs. V. R. Frederick, State President, and other special guests. Presents of small gold gavels, one for each of the presidents of the past ten years, was an important part of this birthday party. Each



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- Proved safe and effective by 6 years' clinical use.
- Soothes the central nervous system, produces calmness without hypnosis.
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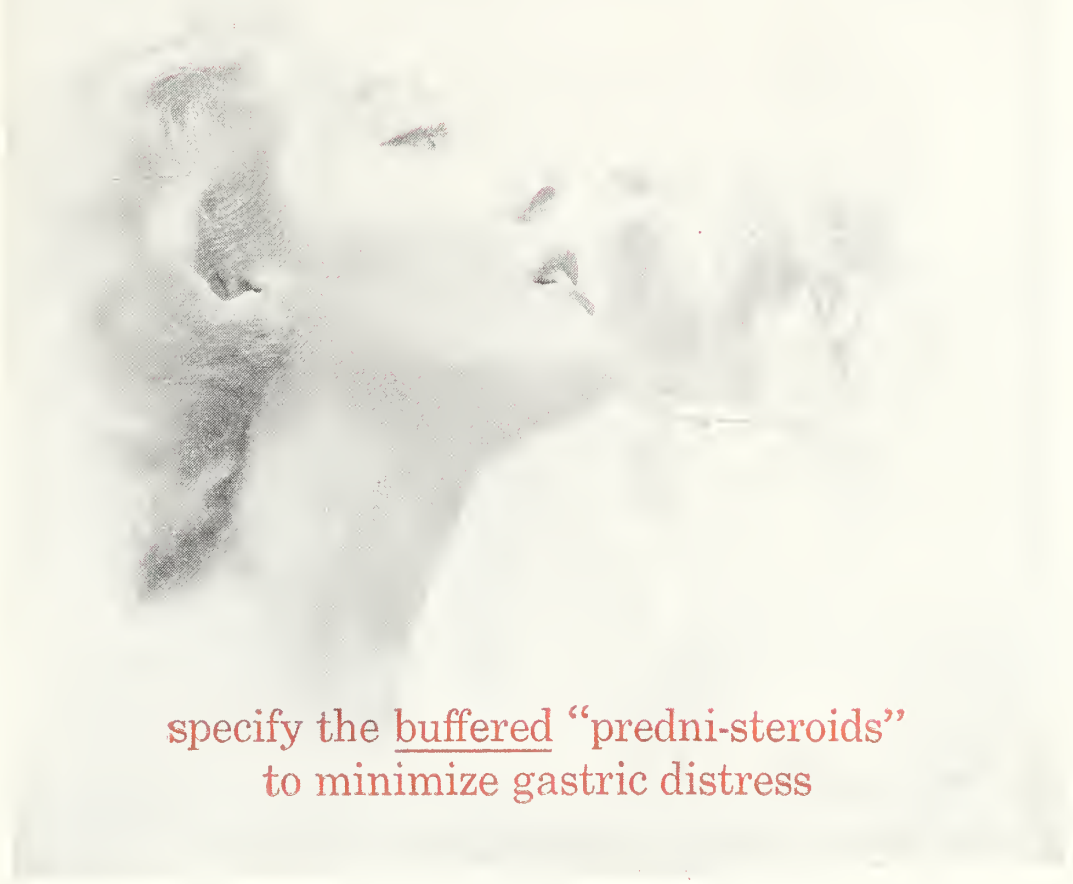


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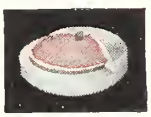
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pin was personalized with engraving indicating the year of the president's term and presented by Mrs. Skirball with words of tribute to each recipient.

Mrs. Ross Knoble presented the paper, prepared by Mrs. D. E. Sheldon, reviewing the Auxiliary's accomplishments of the past 10 years. It emphasized the progress the Auxiliary has made in community service and health education.

Mrs. Frederick, guest of honor, spoke on "Looking Forward," taking up where Mrs. Knoble left off with "Reminiscences."

The chairmen of the various committees gave their reports. The Jenkins-Keough bill was disdiscussed and Mrs. E. Gillette was named to take charge of collections of signatures for letters to go to their congressman.

FAIRFIELD COUNTY

The Woman's Auxiliary to Fairfield Medical Society celebrated 10 years of existence and accomplishments on September 10. It was a day of reminiscing for the members. All 10 past-presidents were seated at the head table.

Mrs. George LeSar, president, welcomed a new member, Mrs. P. Whetstone and conducted a brief business meeting. Mrs. Galon Rodabaugh gave the history of the Auxiliary, and each past-president had an opportunity to say a few words about her year as leader.

Each month a gift is sent to the Nurses Home. Furniture was provided for the living room at the Nurses Home; the recreation room was partly furnished. An annual tea is given for residents at the County Infirmary.

Mrs. Oscar Jepson, an Honorary member, presented the president a gavel made from a newel post from the old St. Francis Hospital in Columbus.

HARDIN COUNTY

The Hardin County Medical Auxiliary meeting was held on September 10, at the Hardin Memorial Hospital, with 12 members present. Dinner was served followed by a business meeting.

Mrs. A. W. Sage was presented a life honorary membership in the Auxiliary. Dr. and Mrs. Sage are leaving Kenton to make their home in California.

Plans for the 9th annual Mistletoe Ball were discussed and Mrs. N. C. Schroeder and Mrs. John Lilly were named co-chairmen.

Members attended the Fall Conference held in Columbus on September 17. Hardin County is honored that one of its members, Mrs. S. P. Churchill is Director of District 3.

HAMILTON COUNTY

Hospitalized voters unable to go to the polls on election day retained their voting privileges again this year through the efforts of the Woman's Auxiliary. Forty-one members volunteered two weeks of concentrated work in eight hospitals, serving as free notaries to patients unable to go to their polling places.

The sale of Christmas cards for the benefit

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—*with a much higher degree of safety*

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of the American Medical Education Foundation is again being sponsored by the Auxiliary. Mrs. Paul Busam, is chairman of the committee.

The members of the Auxiliary Choral group and their husbands enjoyed a picnic on September 1, at the residence of Dr. and Mrs. Robert Krone.

The Auxiliary was represented at the Fall Conference by a delegation of members headed by Mrs. Gaston B. Hannah, president, and Mrs. Earl C. Van Horn, president-elect. Further plans for the year were the subject of an executive board meeting which Mrs. Hannah called at the University Club on September 24.

LAWRENCE COUNTY

The Woman's Auxiliary of Lawrence County has initiated a gift certificate or loan program to aid student nurses or prospective student nurses to further their training. At the meeting on September 16, it was announced that a cash gift certificate of $100.00 would be given to one girl and another girl be given a loan of $200.00. Programs were announced by Mrs. Ralph Massie. Mrs. Charles Gallagher, presiding officer, welcomed the members to this first meeting.

The rummage sale with Mrs. Harry Nenni, general chairman cleared $207.66 for the Nursing Fund.

LOGAN COUNTY

Fourteen members of the Logan County Auxiliary enjoyed a luncheon meeting on September 24 at the Bellefontaine Country Club.

Mrs. George H. Freetage, president, presided for the business meeting. Reports of the Fall Conference of the State Organization were presented. Plans were made for a rummage sale.

MAHONING COUNTY

Twenty-three new members were welcomed into the Woman's Auxiliary at a luncheon on September 12, at Squaw Creek Country Club with Mrs. Cary S. Peabody, president, presiding.

Special guests were Mrs. R. M. Morrison, first president of the Auxiliary, and Mrs. Wm. H. Evans, national vice-president. Mrs. Sidney Franklin reported on the national convention held in New York and aims of the organization were reviewed by Mrs. Earl Young.

Mrs. Allen Seward, vice-president of the Youngstown Federation of Women's Clubs, was the guest speaker and gave a humorous monologue on flower arranging.

Mrs. Robert Tornello reported on the nurse scholarship dance scheduled for November. Proceeds from dance will provide nursing scholarships to a student at the Youngstown Hospital School of Nursing and to one at the St. Elizabeth Hospital School of Nursing.

RICHLAND COUNTY

The Woman's Auxiliary to Richland County Medical Society opened its fall season with a luncheon on September 9 at the Women's Club. Hostesses were five members from Shelby. Mrs. Paul J. Lee, president, presided for the business meeting. Mrs. Oakes, vice-president, distributed the programs for the year. The members voted to make cash contributions instead of sponsorlng money-making projects this year.

Nurse recruitment is one of the organization's major projects as is the American Medical Education Fund. Copies of *Today's Health* are given by the Auxiliary to schools and institutions with subscriptions sold to others. The Auxiliary's famed "silent auction" will be a feature of the December meeting.

ROSS COUNTY

Mrs. Richard Ritter, Columbus, was a guest at the meeting of the Woman's Auxiliary on September 6, at the Lynne House. Mrs. Ritter's husband was speaker at the Medical Society meeting also held the same evening.

Mrs. Robert Swank was the presiding officer. The Nurse Recruitment chairman reported there have been no candidates for the loan fund. Tentative plans were made to organize a club composed of high school girls interested in entering the nursing profession. The Auxiliary was told about the proposed Prepared Motherhood Classes scheduled to begin in November. Nurses at Chillicothe Hospital will conduct the classes. Reports were given on the sale of *Today's Health* and the theme of the essay contest will be "The Importance of the Free Enterprise System."

Mrs. Walter Kramer, district director, discussed the District 10 meeting to be held in Chillicothe.

Mrs. John Franklin, Sr., conducted the meeting of Hospital Guild 1 following the Auxiliary session. She stressed the need for workers in the hospital snack shop. She also announced a style show and card party sponsored by Hospital Guild 6.

SCIOTO COUNTY

Plans for a telephone bridge to be held were outlined by Mrs. Robert Counts, chairman of ways and means committee, when the Woman's Auxiliary met for a luncheon meeting at Star Sales Co., on September 11. Proceeds from the telephone bridge will go to the American Medical Education Foundation and the nurses's Fund.

Mrs. W. C. Hugenberg, president, presented a budget report and Mrs. McDonald, chairman of the nurse's fund, reported a 1957 graduate of Rush Township High School was recipient of the scholarship to Mercy Hospital, School of Nursing.

Representative of Geneva Kitchens and a home economist for the Ohio Power Co. were the guest speakers.

Officers, chairmen and members attended the Fall Conference held in Columbus.

SUMMIT COUNTY

On August 15, the Woman's Auxiliary to the Summit County Medical Society started its year

(Continued on Page 1350)

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with its annual fund raising project. The Hat Parade and Garden Party was held at the homes of Dr. and Mrs. Alexander Ormond and Dr. and Mrs. Robert DeWitt. More than 400 women were seated in an amphitheater setting provided by the garden of Mrs. Ormond for the hat show. Members enjoyed bridge and refreshments on the adjoining lawn of Mrs. DeWitt. This was Summit County's fifth annual show. The proceeds go to their Nurses' Revolving Loan Fund, at Akron Hospitals.

The Auxiliary was one of two sponsors for the Oldsters' Hobby Show held on September 6-7-9 at O'Neil's. Mrs. Anthony Vamvas was the chairman of the show. The show was for exhibits of handiwork by any one in Summit County 65 or over. Any type of work or hobby done during the past year is eligible for exhibit. Ribbons and certificates were given to the prize winners. A member of the Auxiliary was present at the show to help with taking orders for the entrants' handiwork and to arrange for the orders to be filled.

TRUMBULL COUNTY

The Trumbull County Medical Auxiliary held its first meeting of the fall on September 18, at Trumbull Country Club. Mrs. Clyde Muter, president, presided at the meeting which followed dinner with members of the Medical Society. The guest speaker for the evening was Mr. David Chenowith, Trust officer of the Union Savings and Trust Co., who gave a very informative talk on "The Purpose of Estate Planning."

The Future Nurses' Club of Harding High School recently took part in a panel discussion concerning health careers. The discussion was led by four members of the Auxiliary. The club is sponsored by the school nurse and is a service club as they volunteer their services at the hospital and the school dispensary. The meeting was held to stimulate interest in nursing and all health careers.

TUSCARAWAS COUNTY

To stimulate attendance, in September 1956, the members were divided into two teams appropriately named "Red Bill" and "Pink Pills." The losers were announced at the last meeting in June 1957 and were to treat the winners at the first meeting this fall. On September 12, at the home of Mrs. Harold Wherley in Stonecreek, a smorgasbord dinner was served to the "Pink Pills" with the "Red Bills" as hostesses.

An arrangement of autumn flowers centered the buffet table and at each place was an autumn corsage with personalized program books for the coming year. The remainder of the evening was spent at cards and getting acquainted with the new members.

Eight members attended the Fall Conference in Columbus.

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Executive Secretaries of County Societies Meet in Columbus For Discussions

Keen interest and lively discussion carried throughout a heavy docket October 11 when executive secretaries of county medical societies met in Columbus for a "let's talk it over" session with the OSMA headquarters staff.

Purpose of the meeting was to provide an interchange of ideas and policies on problems and activities of county medical societies. The 16-item docket for the afternoon session included the following:

Types, frequency and attendance for meetings; bulletin publication, voluntary health agency relationships, Aid for the Aged health care program, availability of dogs for medical research, legislative activities, local Asian flu plans, press, radio and television relationships, model constitution and by-laws, collection of membership dues, interchange of news items between OSMA and local bulletins, American Medical Education Foundation, suggestions for program for OSMA county society officers meeting in Columbus March 2, 1958; handling of complaints and grievances, suggestions for OSMA annual meeting, and industrial medicine problems.

Moderator for the afternoon program was OSMA Executive Secretary Charles S. Nelson.

OSMA President and Mrs. Robert S. Martin were guests of honor at a dinner that evening, at which time Dr. Martin complimented the secretaries for their contributions to and interest in medical societies.

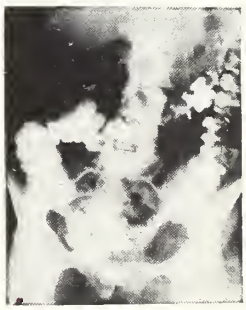
That night's program was given over to the problems and situations encountered in operating medical business bureaus and telephone answering services. Moderator for the evening was Robert W. Elwell, executive secretary of the Academy of Medicine of Toledo and Lucas County, with Stanley R. Mauck, owner and operator of the Columbus Medical Bureau and Telephone Answering Service, as the resource person. Mr. Mauck is a former executive secretary of the Columbus Academy of Medicine.

Also attending the meeting were the following executive secretaries: Edward F. Willenborg, Academy of Medicine of Cincinnati; M. John Hanni, Cleveland Academy of Medicine, Mrs. Owen A. McLaren, Lake County Medical Society, William Webb, Jr., Columbus Academy of Medicine, E. M. Sprunger, Stark County Medical Society; Charles G. Greig, Butler County Medical Society, and Paul Herald, Mahoning County Medical Society.

Attending from the OSMA headquarters staff, in addition to Mr. Nelson, were George H. Saville, director of public relations and assistant executive secretary; Hart F. Page, assistant director of public relations; R. Gordon Moore, news editor of

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The Ohio State Medical Journal, and Charles W. Edgar, administrative assistant.

Robert F. Freeman, executive secretary of the Montgomery County Medical Society was unable to attend because of the illness of his mother, and Miss Betty Haydon, office secretary of the Summit County Medical Society, was unable to attend because of a previous commitment.

Health Insurance Association Adopts Code of Ethics

The recently adopted Code of Ethical Standards of the Health Insurance Association of America, has been produced in leaflet form and is being distributed to the Association membership. The Code lists nine specific points governing the sale, administration and advertising of voluntary health insurance, and has become a strict condition of membership in the Association. The text of the code to which each member organization pledges itself is as follows:

Offer only insurance providing effective and real protection against such loss as the policy is designed to cover

Write its policies in clear and direct language without unreasonable restrictions and limitations

Advertise its policies in such manner that the public can readily understand the protection offered, and not use advertising which has the tendency or capacity to mislead or deceive

Select, train, and supervise personnel of integrity in a manner which will assure intelligent, honest, courteous sales and service

Engage only in sales methods, promotional practices and other transactions which give primary consideration to the needs, interest, and continued satisfaction of the persons insured

Endeavor to establish the insurability of persons at the time of application in every instance where such insurability is a factor in the issuance or continuance of the insurance or in the liability of the insurer

Pay all just claims fairly, courteously, and promptly, with a minimum of requirements

Continue research and experimentation in order to meet the changing needs of the public

Engage in keen, fair competition so the public may obtain the protection it needs at a reasonable price.

COMING MEETINGS

Ohio State Medical Association, 1958 Annual Meeting, April 15, 16 and 17, Cincinnati.

American Medical Association, Clinical Session, Philadelphia, Pa., December 3-6.

American College of Chest Physicians, Regional Interim Session, Philadelphia, Pa., December 2-3.

American School Health Association, Hollenden Hotel, Cleveland, November 16.

County Medical Societies Civil Defense Conference, November 9-10, Chicago.

INDEX TO ADVERTISERS

Abbott Laboratories ..... 1254 - 1255, 1351
American Meat Institute 1237
American Medical Education Foundation 1317, 1322
Ames Company, Inc. 1272
Appalachian Hall 1244
Ayerst Laboratories, Inc. 1350, 1356
and insert between pages ..... 1356 - 1357
Baker Laboratories, Inc. 1238
Barry Laboratories, Inc. 1263
Bayer Company, The, Div. of Sterling Drug, Co., Inc. 1271
Burroughs, Wellcome & Co. (U.S.A.) Inc. 1230, 1371
and insert between pages ..... 1244 - 1245
Chicago Medical Society 1352
Ciba Pharmaceutical Products, Inc. 1369
Columbus Pharmacal Company 1366
Cook County Graduate School of Medicine 1340
Corn Products Refining Co. 1234
Davies, Rose & Co., Ltd. 1344
Endo Products, Inc. 1257
Flint, Eaton & Company 1370
Geigy Pharmaceuticals, Inc. 1365
Harding Sanitarium 1247
Kaiser Aluminum & Chemical Corporation 1339
Lakeside Laboratories, Inc. 1229
Lederle Laboratories ..... 1243, 1244, 1248 - 1249, 1258, 1310-1311, 1347, 1353, 1359, 1367
Lewal Pharmaceutical Company 1246
Lilly, Eli, and Company 1276
Lloyd Brothers, Inc. 1239
Loma Linda Food Company 1264
Mallard, Inc. 1342
McMillen Sanitarium 1247
Mead Johnson & Company, Pablum Products Division 1364
Medical Protective Company 1347
Merck Sharp & Dohme 1265, 1343, 1363
Neil Training School 1355
North, Emerson A., Hospital, The 1270
New York Polyclinic Medical School 1366
Parke, Davis & Company 1323, 1372
and Inside Back Cover
Pfizer, Chas. & Co., Inc. ..... 1360 - 1361
Picker X-Ray Corporation 1261
Rich Company, Incorporated 1362
Riker Laboratories, Inc. 1273
Robins, A. H., Co., Inc. ..... 1268 - 1269, 1274, 1345, 1358 and insert between pages 1332 - 1333
Roche Laboratories, Division of Hoffmann-La-Roche, Inc., ... insert between pages 1340 - 1341
Roerig, M. B., & Co. ..... 1240 - 1241, 1349
Sawyer Sanatorium 1256
Schering Corporation ..... 1236, and insert between pages 1236 - 1237; 1252 - 1253
Scroggins, Clayton L., Associates (Medical-Dental Management) 1358
Searle, G. D., & Company 1337, 1352
Smith, Kline & French Laboratories 1275
and Back Cover
Squibb, E. R., & Sons, Division of Olin-Mathieson Chemical Corporation 1357
Stanco Laboratories 1340
Stoneman Press 1258
Tutag, S. J., & Company 1274
Upjohn Company 1235
Vale Chemical Company, Inc. 1348
Wallace Laboratories ..... Insert between Pages 1364-1365
Warren-Teed Products Co., The 1242
Wendt-Bristol Company 1347
Windsor Hospital, Inc. 1341
Winthrop Laboratories 1262, 1318-1319, 1368
and inserts between 1260-1261 and 1316 - 1317

Classified Advertisements

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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PRACTICE AND EQUIPMENT of the late Dr. Joseph Friedberger, Urbana, for sale; office available for rent. Contact Mrs. Friedberger, 827 S. Main St., Urbana; Phone 3-3457.

Marriage Counseling Discussed by Cincinnati Area GP's

A series of four programs on the theme "Marriage Counseling by the General Physician" was conducted by the Southwestern Ohio Society of General Physicians in collaboration with the University of Cincinnati College of Medicine. Topics and speakers were the following:

October 10—"The Childless Marriage," moderator, Dr. Richard Bryant; speakers, Dr. Robert Pierce and Dr. William Mulvaney.

October 17—"The Psychologic and Legal Aspects of Marriage," Dr. Robert Buckley, and Stanley Harper, professor of law, Chase College.

October 24—"The Social Hygiene of Marriage," Roy E. Dickerson, executive secretary of the Cincinnati Social Hygiene Society.

October 31—"The Religious Obligations of Marriage," moderator, Dr. G. L. Waldon; speakers, Rabbi V. Reichert, Monsignor Joseph Schneider, and the Reverend Kenneth Clarke.

The next seminar topic will be "Pathology of the Male Perineal Organs," on November 24 in the Victory Room, Sheraton-Gibson Hotel, from 9:00 a. m. to 3:15 p. m.

Dr. J. H. Persinger, Washington, C. H., has been named a trustee of Wilmington College, Wilmington, of which he is an alumnus.

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Committee on State Legislation (1957-1958)—John A. Fraser, East Liverpool, Chairman; John A. Fisher, Cincinnati; W. W. Trostel, Piqua; Floyd M. Elliott, Ada; George A. Boon, Oak Harbor; E. A. Ferreri, Cleveland; John R. Seesholtz, Canton; Jay W. Calhoon, Uhrichsville; James B. Johnson, Newark; Clyde M. Fitch, Portsmouth; Robert J. Murphy, Columbus; R. L. Mansell, Medina.

Committee on National Legislation (1957-1958)—Fred. W. Dixon, Cleveland, Chairman; John A. Fisher, Cincinnati; A. Ward McCally, Jr., Dayton; W. W. Trostel, Piqua; George A. Boon, Oak Harbor; Clyde M. Fitch, Portsmouth; Floyd M. Elliott, Ada; J. Howard Holmes, Toledo; Ralph F. Massie, Ironton; Joseph A. Browning, Warren; Robert J. Murphy, Columbus; Paul J. Kopsch, Lorain; Donald I. Minnig, Akron; William L. Denny, Cambridge; John R. Seesholtz, Canton; James B. Johnson, Newark; John A. Fraser, East Liverpool; Craig C. Wales, Youngstown; E. A. Ferreri, Cleveland; C. W. Hullinger, Springfield.

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Committee on National Defense (1957-1958)—Drew L. Davies, Columbus; C. C. Sherburne, Columbus; Robert Conard, Wilmington, members-at-large. **Subcommittee on Civil Defense (1957-1958)**—C. C. Sherburne, Columbus, Chairman; Frank P. Cleveland, Cincinnati; G. G. Floridis, Dayton; Charles H. Leech, Lima; Orrin C. Keller, Toledo; Charles L. Leedham, Cleveland; A. H. Kyriakides, Akron; F. B. Harrington, Steubenville; Paul A. Jones, Zanesville; Thomas W. Morgan, Gallipolis; David K. Heydinger, Columbus; Herbert Rosenbaum, Lorain. **Military Advisory Subcommittee (1957-1958)**—Drew L. Davies, Columbus, Chairman; Robert Conard, Wilmington, member-at-large; David A. Tucker, Jr.,

(Continued on next page)

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Committee on Rural Health (1957-1958)—Edmond K. Yantes, Wilmington, Chairman; L. E. Anderson, Greentown; J. Martin Byers, Greenfield; E. G. Caskey, Mineral Ridge; Jonathan Forman, Dublin; V. R. Frederick, Urbana; Carl F. Coll, Steubenville; L. W. High, Millersburg; H. R. Mayberry, Bryan; Carll S. Mundy, Toledo; W. L. Murphy, Cardington; Robert E. Reiheld, Orrville; G. N. Spears, Ironton; H. K. Van Buren, Carey; Kenneth Taylor, Pickerington; D. S. Williams, Marietta.

Committee on School Health (1957-1958)—Thomas E. Shaffer, Columbus, Chairman; Charlotte Ames, Xenia; Elizabeth Rowland-Aplin, Columbus; Margaret E. Belt, Lima; Richard R. Buchanan, Wilmington; Walter Felson, Greenfield; Walter F. Heine, Circleville; Howard H. Hopwood, Jr., Cleveland; Dale A. Hudson, Piqua; Charles L. Kagay, Dayton; Robert A. Lyon, Cincinnati; Charles H. McMullen, Loudonville; Margaret O'Neal, Zanesville; J. M. Painter, Kent; Carl L. Petersilge, Newark; Robert C. Markey, Bowling Green; William S. Rothe, Bowling Green; Richard H. Schaefers, Wapakoneta; J. I. Rhiel, Port Clinton; H. B. Thomas, Gallipolis; J. W. Wilce, Columbus; Carl A. Wilzbach, Board of Health, City Hall, Cincinnati.

Woman's Auxiliary Advisory Committee (1957-1958)—James R. Jarvis, Van Wert, Chairman; Carl A. Gustafson, Youngstown; C. L. Pitcher, Portsmouth.

DELEGATES AND ALTERNATES

Delegates and Alternates to the American Medical Association—Paul A. Davis, Akron; Edmond K. Yantes, Wilmington, alternate; Charles L. Hudson, Cleveland; C. E. Hufford, Toledo, alternate; Carl A. Lincke, Carrollton; H. M. Platter, Columbus, alternate; Carll S. Mundy, Toledo; Paul F. Orr, Perrysburg, alternate; L. Howard Schriver, Cincinnati; E. O. Swartz, Cincinnati, alternate; C. C. Sherburne, Columbus; Richard L. Meiling, Columbus, alternate; George A. Woodhouse, Pleasant Hill; R. Dean Dooley, Dayton, alternate; Herbert B. Wright, Cleveland; Fred W. Dixon, Cleveland, alternate.

County Societies' Officers and Meeting Dates

FIRST DISTRICT

ADAMS—Sam C. Clark, President, Cherry Fork; Hazel L. Sproull, Secretary, West Union. 3rd Wednesday, April, June, August, October, December.

BROWN—John R. Donohoo, President, Georgetown; Leslie Hampton, Jr., Secretary, Sardinia. 1st Sunday, monthly.

BUTLER—Ralph H. Leyrer, President, Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton. Beginning in February 4th Wednesday of alternate months.

CLERMONT—Charles M. Simmons, President, Bethel; John T. Crone, Secretary, Milford. 3rd Wednesday, monthly.

CLINTON—John K. Williams, President, Wilmington; Edmond K. Yantes, Secretary, Wilmington. 1st Tuesday.

HAMILTON—George X. Schwemlein, President, Cincinnati; Mr. Edward F. Willenborg, Executive Secretary, 152 East 4th Street, Cincinnati. 2nd Tuesday, monthly.

HIGHLAND—Richard C. Wenrick, President, Hillsboro; Leland Dale McBride, Secretary, Hillsboro. Selected monthly.

WARREN—Howard G. Berninger, President, Lebanon; D. Paul Ward, Secretary, Pleasant Plain. 2nd Tues., monthly.

SECOND DISTRICT

CHAMPAIGN—Myron Towle, President, Urbana; John R. Polsley, Secretary, North Lewisburg. 2nd Wed., monthly.

CLARK—John D. LeFevre, President, Springfield; Charles E. Fralick, Secretary, Springfield. 3rd Monday, monthly.

DARKE—E. Westbrook Browne, President, Greenville; Maurice M. Kane, Secretary, Greenville. 3rd Tuesday, monthly, except June, July, August, December.

GREENE—Joseph R. Schauer, President, Fairborn; Norman G. Linton, Secretary, Jamestown. 2nd Thursday, monthly.

MIAMI—Charles M. Oxley, President, Troy; Dale A. Hudson, Secretary, Piqua. 1st Friday, monthly, except July, August.

MONTGOMERY—R. Dean Dooley, President, Dayton; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Building, Dayton. 1st Friday, monthly, except July, August and September.

PREBLE—E. P. Trittschuh, President, Lewisburg; John R. Bowman, Secretary, Eaton. November of each year.

SHELBY—James W. Tirey, President, Anna; Robert H. Lanfersieck, Secretary, Sidney. 1st Tuesday, monthly.

THIRD DISTRICT

ALLEN—David L. Steiner, President, Lima; Thomas D. Allison, Secretary, Lima. 3rd Tuesday, monthly, except June, July and August.

AUGLAIZE—William V. Barton, President, St. Marys; Dale L. Kile, Secretary, St. Marys.

CRAWFORD—Charles J. Griebling, President, Galion; James E. Loggins, Secretary, Galion. 3rd Friday, monthly.

HANCOCK—R. Grant Janes, President, Findlay; Benjamin H. Saunders, Jr., Secretary, Findlay. 3rd Tuesday, monthly.

HARDIN—Richard A. Dietrich, President, LaRue; Wm. F. Binkley, Secretary, Kenton. 2nd Tuesday, monthly.

LOCAN—Charles H. Thompson, President, West Mansfield; Charles A. Browning, Jr., Secretary, Bellefontaine.

MARION—John T. Boxwell, President, Marion; Thomas N. Quilter, Secretary, Marion. 1st Tuesday, monthly.

MERCER—Robert M. Fell, President, Celina; Julius Schwieger, Secretary, Fort Recovery. 3rd Thursday, monthly.

SENECA—Leonard M. Caydos, President, Tiffin; Thomas W. Watkins, Secretary, Tiffin. 3rd Tuesday, monthly.

VAN WERT—Edwin Wm. Burnes, President, Van Wert; Norman L. Marxen, Secretary, Van Wert. 1st Friday.

WYANDOT—Richard L. Garster, President, Upper Sandusky; Allen F. Murphy, Secretary, Upper Sandusky. 2nd Tues.

FOURTH DISTRICT

DEFIANCE—John F. Holtzmuller, President, Defiance; George L. Boomer, Secretary, Defiance. 1st Saturday.

FULTON—Edwin R. Murbach, President, Archbold; Robert A. Ebersole, Secretary, Archbold. 4th Tuesday, monthly.

HENRY—Bernard J. George, President, Liberty Center; Thomas F. Tabler, Secretary, Holgate. 1st Tuesday.

LUCAS—Max T. Schnitker, President, Toledo; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo. 3rd Tuesday, monthly.

OTTAWA—Cyrus R. Wood, President, Port Clinton; F. Kraft Ritter, Secretary, Port Clinton. 2nd Thurs., monthly.

PAULDING—T. P. Fast, President, Grover Hill; John H. Schaefer, Secretary, Paulding.

PUTNAM—James B. Overmier, President, Leipsic; Will W. Moody, Secretary, Vaughnsville. 1st Tuesday, except June, July and August.

SANDUSKY—Karl K. Grubaugh, President, Woodville; R. Allen Eyestone, Secretary, Gibsonburg. 3rd Wednesday, monthly, except June, July and August.

WILLIAMS—Robert A. Gilreath, President, Bryan; Robert W. Dilworth, Secretary, Montpelier. 3rd Tues., monthly.

WOOD—J. Victor Pilliod, President, Grand Rapids; Richard L. Pearse, Secretary, Bowling Green. 3rd Thurs., monthly.

FIFTH DISTRICT

ASHTABULA—Harold C. Franley, President, Jefferson; Arthur B. Shaul, Secretary, Ashtabula. 2nd Tuesday.

County Societies' Officers and Meeting Dates (Continued)

CUYAHOGA—Thomas D. Kinney, President, Cleveland; Mr. M. John Hanni, Jr., Executive Secretary, 2009 Adelbert Road, Cleveland. 2nd Tuesday, monthly.

GEAUGA—Walter C. Corey, President, Chardon; Alton W. Behm, Secretary, Cbardon. 2nd Friday, monthly.

LAKE—Anthony J. DiCello, President, Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Avenue, Mentor. 2nd Tuesday, montbly.

SIXTH DISTRICT

COLUMBIANA—Robert N. Osmundsen, President, Salem; Richard J. McConnor, Secretary, Salem. 3rd Tues., monthly.

MAHONING—Stephen W. Ondash, President, Youngstown; Mrs. Mary B. Herald, Executive Secretary, 125 Commerce Street, Youngstown. 3rd Tuesday, monthly.

PORTAGE—Robert E. Roy, President, Ravenna; George R. Sprogis, Secretary, Hiram. 3rd Tuesday, monthly.

STARK—R. E. Tscbantz, President, Canton; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton. 2nd Thursday, monthly.

SUMMIT—Robert G. McCready, President, Akron; Miss Betty Haydon, Office Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly, September through June.

TRUMBULL—Joseph A. Browning, President, Warren; Robert J. Willoughby, Secretary, Warren. 3rd Wed., monthly.

SEVENTH DISTRICT

BELMONT—A. John Antalis, President, Powhatan Point; Bertha M. Joseph, Secretary, Martins Ferry. 3rd Thursday, except July, August.

CARROLL—P. S. Whiteleather, President, Minerva; Robert H. Hines, Secretary, Minerva.

COSHOCTON—John L. Magness, President, Coshocton; Harold W. Lear, Secretary, Coshocton. 2nd Tuesday, monthly.

HARRISON—Carl J. Nicosia, President, Bowerston; Richard W. Weiser, Secretary, Jewett. Meetings: March, June, September, December.

JEFFERSON—Warren G. Snyder, President, Wintersville; Frances J. Sbaffer, Secretary, Toronto. 2nd Tuesday.

MONROE—Byron Gillespie, President, Woodsfield; Albert R. Burkhart, Secretary, Woodsfield.

TUSCARAWAS—Paul D. Hahn, President, New Philadelphia; Artbur J. Stevenson, Secretary, New Philadelphia. 2nd Thursday, monthly.

EIGHTH DISTRICT

ATHENS—Eleanora Schmidt, President, Athens; Charles R. Hoskins, Secretary, Athens. 2nd Tuesday, monthly.

FAIRFIELD—George F. Jones, President, Lancaster; Arthur B. VanGundy, Secretary, Lancaster. 2nd Tuesday, monthly.

GUERNSEY—John Wm. Camp, President, Cambridge; Albert C. Smith, Jr., Secretary, Cambridge. 1st Thurs., monthly.

LICKING—Clarence G. Faue, President, Newark; Paul N. Montalto, Secretary, Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, McConnelsville. Called Meetings.

MUSKINGUM—William B. Faircloth, President, Zanesville; William A. Knapp, Secretary, Zanesville. 1st Tuesday.

NOBLE—Norman S. Reed, President, Caldwell; Edward G. Ditch, Secretary, Caldwell. 2nd Tuesday, monthly.

PERRY—C. B. McDougal, President, New Lexington; O. D. Ball, Secretary, New Lexington. Called meetings.

WASHINGTON—Deane H. Northrup, President, Marietta. Joseph E. LaBarre, Secretary, Marietta. 2nd Wednes., monthly.

NINTH DISTRICT

GALLIA—John C. Markley, President, Gallipolis; Robert P. Carson, Secretary, Gallipolis. Last Thursday, monthly.

HOCKING—Howard M. Boocks, President, Logan; Richard C. Jones, Secretary, Logan.

JACKSON—Alvis R. Hambrick, President, Wellston; Brinton J. Allison, Secretary, Oak Hill. Called Meetings.

LAWRENCE—Harry Nenni, President, Ironton; George Newton Spears, Secretary, Ironton. 2nd Tuesday, monthly.

MEIGS—Joseph J. Davis, President, Middleport; Charles J. Mullen, Secretary, Pomeroy.

PIKE—Cecil L. Grumbles, President, Waverly; Benton V. D. Scott, Secretary, Waverly. 1st Tuesday, monthly.

SCIOTO—Joseph T. Gohmann, President, Portsmouth; Carl H. Laestar, Secretary, Portsmouth. 2nd Monday, monthly.

VINTON—Richard E. Bullock, President, McArthur; H. D. Chamberlain, Secretary, McArthur.

TENTH DISTRICT

DELAWARE—Emerson V. Arnold, President, Delaware; F. M. Stratton, Secretary, Delaware. 3rd Tuesday, monthly.

FAYETTE—Frank C. King, President, Washington C. H.; H. Wm. Payton, Secretary, Jeffersonville. 2nd Tuesday.

FRANKLIN—Norman O. Rothermich, President, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus 15. Monthly meeting dates discontinued; Will meet in January, March, June and October.

KNOX—James C. McLarnan, President, Mt. Vernon; Clinton W. Trott, Secretary, Mt. Vernon. 1st Thursday.

MADISON—Ernest S. Crouch, President, London; Robert S. Postle, Secretary, London. 1st Wednesday, monthly.

MORROW—Joseph P. Ingmire, President, Mt. Gilead; Lowell Murphy, Secretary, Cardington. 1st Tuesday, monthly.

PICKAWAY—Ray Carroll, President, Circleville; E. L. Montgomery, Secretary, Circleville. 1st Friday, monthly.

ROSS—Charles N. Hoyt, President, Chillicothe; Robert E. Quinn, Secretary, Chillicothe. 1st Thursday, monthly.

UNION—Paul Richard Zaugg, President, Marysville; May B. Zaugg, Secretary, Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—Charles H. McMullen, President, Loudonville; William H. Rower, Secretary, Ashland. 1st Friday, monthly.

ERIE—Herbert F. Kesinger, President, Sandusky; Edward Gillette, Secretary, Sandusky. 4th Thursday, monthly.

HOLMES—Luther W. High, President, Millersburg; Owen F. Patterson, Secretary, Millersburg. 2nd Wednesday.

HURON—William W. Corwin, President, Willard; John V. Emery, Secretary, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—James T. Stephens, President, Oberlin; Conrad T. Rusin, Secretary, Lorain. 2nd Tuesday, monthly.

MEDINA—Christian F. Schrier, President, Litchfield; Robert E. Smith, Secretary, Medina. 3rd Thursday, monthly.

RICHLAND—Harry Wain, President, Mansfield; Riley E. Frusn, Secretary, Mansfield. 3rd Thursday, monthly.

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(1) Asung, C. L.; Charcowa, A. I., and Villa, A. P.: Sea View Hosp. Bull. *16*:80, 1956. (2) Asung, C. L.; Charcowa, A. I., and Villa, A. P.; New York J. Med. *57*:1911 (June 1) 1957. (3) Report on Field Screening of Nostyn by 99 Physicians in 1,000 Patients, June, 1956.

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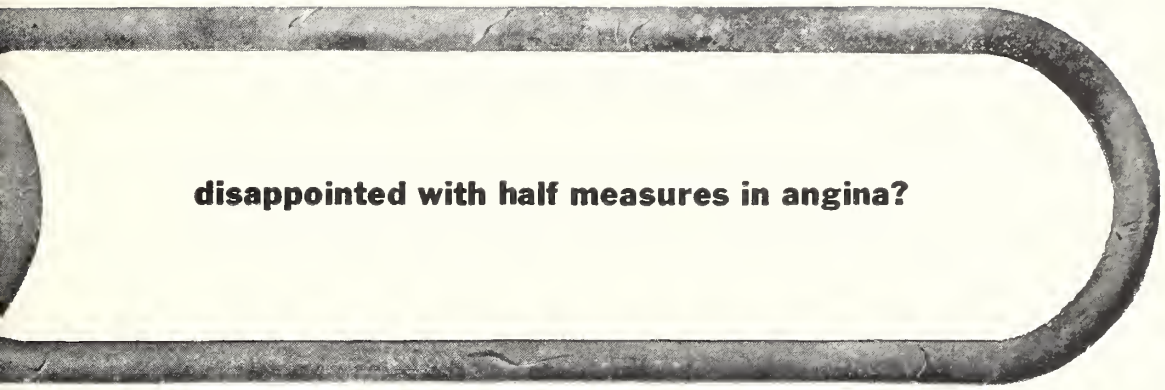
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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

Nursing Pathology, by Raymond H. Goodale, M. D. ($4.50. Second Edition. *W. B. Saunders Co., Philadelphia 5, Pa.)* The branches of medicine continue to advance and the nurses must keep up with these advances insofar as pertaining to their work. This edition of this manual satisfies these requirements.

Surgery for General Practice, by Victor Richards, M. D. ($17.50. *C. V. Mosby, St. Louis 3, Missouri.)* This book will be of real usefulness to the average physicians caring for the majority of surgical problems in the everyday practice of medicine. It is an effort to organize, for the average physician, surgical facts in a usable, practical array in order that patients may receive better care.

Of Water, Salt and Life, by Lakeside Laboratories, Inc., Milwaukee 1, Wis. ($7.50. *Lakeside Laboratories Inc., 1707 E. North Ave., Milwaukee 1, Wis.)* An atlas of fluid and electrolyte balance in health and disease, this reference book incorporates the abundant new knowledge concerning an increasingly significant area of clinical medicine. Two developments in research technics, the flame photometer and the use of radioactive isotopes as tracers, have made possible more accurate measurements and precise evaluation in diagnosis and therapy. Many of the investigators whose work has contributed to current knowledge, are cited in the bibliography.

Psychopharmacology, edited by Nathan S. Kline. ($3.50. Publication No. 2, *American Association for the Advancement of Science, 1515 Massachusetts Ave., N. W., Washington, D. C.)* Symposium from the Section on Medical Sciences of the A. A. A. S. and is largely devoted to chlorpromazine and research.

Clinical Laboratory Diagnosis, by Samuel A. Levinson, M. D., and Robert MacFate, M. D. ($12.50. Fifth Edition. *Lea and Febiger, Philadelphia 6, Pa.)* In keeping abreast with the progress in clinical pathology some chapters have been completely rewritten and a great many changes and revisions have been made throughout the text.

Heart Disease, Second Edition, 601 pp. Diagnosis and Treatment, 107 Illustrations, by Emanuel Goldberger, M. D. ($10.00. *Lea and Febiger, Philadelphia 6, Pa.)* The chapter on heart failure has been enlarged to include a discussion on etiology and treatment of electrolyte disturbances such as the low sodium syndrome, the low chloride syndrome and the high chloride. There is also new material on other methods of treatment; patent ductus arteriosus with pulmonary hypertension.

Woman's Doctor, by Russell Boltar. ($3.50. *Julian Messner, Inc., New York 18, N. Y.)* A rather sordid story of how a brilliant Gynecologist gets enmeshed in cafe society.

Occupational Health Nursing, by Mary Louise Brown, R. N. ($4.50. *Springer Publications Co., New York 10, N. Y.)* This book attempts to orient the students who are interested in a career in industry and offers to guide the practicing, occupational health nurse by giving her standards and plans with which to measure her own specific program and performance.

Consultation Room, by Frederic Loomis, M. D. ($0.25. *Pocket Books Inc., New York, N. Y.)* This is a pocket edition of larger book without abridgement by the well known gynecologist.

Physician's Handbook, assembled and edited by Drs. Krupp and Armstrong of Stanford and Jawetz and Sweet of California. ($3.00. Ninth Edition. *Lange Medical Publications, Los Altos, California.)* With much new material added, this handbook offers in readily accessible form a source of factual data, laboratory procedures and clinical aids repeatedly used in all branches of medicine. It is handy for the pocket or the satchel.

Head Injuries and Their Management, by Francis Asbury Echlin, M. D. ($3.00. *J. B. Lippincott Co., Philadelphia 5, Pa.)* A well written concise monograph on what to do and what not to do when confronted with a patient having an injury of the head.

Nurse-Patient Relationships in a Hospital Maternity Service, by Marion S. Lesser, M. A., and Vera R. Keane, B. S., C. N. M. ($4.25. *C. V. Mosby, St. Louis, Mo.)* This book brings into focus not only what nurses do but what the function means to them and to the public whom they serve. Here we find where and why problems and dissatisfactions exist.

Treatment of the Child in Emotional Conflict, by Hyman S. Lippman, M. D. ($6.00. *Blakiston Division, McGraw-Hill Book Co., New York 36, New York.)* After 25 years in a child guidance clinic, the author brings a warm and understanding recital of his views on therapy of such children. Dr. William C. Menninger recommends the book as a "must" for all workers dealing with troubled children.

Dust is Dangerous, by C. N. Davies, D. Sc. ($4.50. *Faber and Faber Ltd., 24 Russell Square, London, England* (Distributed in U. S. A. by *John de Graff Inc., 64 W. 23rd St., New York 10, New York.)* All of our activities produce dust. Incorporated in it may be fungi, bacteria, or virus

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microbes. Many uninformed people have been brought into contact with poisonous inhalants—both by industry and agriculture. This is an excellent summary of our present-day knowledge.

Cytology of the Blood and Blood-Forming Organs, by Marcel Bessis, M. D. ($22.00. *Grune & Stratton, Inc., New York 16, N. Y.)*, translated from the French by Eric Ponder. In this study, descriptions as found in classical hematology are presented, but they occupy a secondary place in comparison with the description of the results of studies of cells in their living state and of their ultra structure as seen with the electronic microscope.

Nursing Care of the Newly Born Infant, by William S. Craig with the collaboration of M. F. G. Buchanan, R. J. Pugh, Miss M. Pattullo, and Miss M. J. W. Taylor. ($7.00. *E. S. Livingstone Ltd., Edinburgh;* United States Distributor, *Williams and Wilkins, Baltimore 2, Md.)* The emphasis of this book is based on the fundamental importance of clinical observation in the professional care of newborn infants. Although intended primarily for the midwife and the family doctor, it will prove of value to all concerned with clinical problems presented by the newborn infant.

Ageing in Transient Tissues, Vol. II, edited by G. E. W. Wolstenholme, M. B., and Elaine C. P. Millar. ($6.75. *Little Brown and Co., Boston, Massachusetts.)* This is the second Colloquia on Ageing for the Ciba Foundation. The subject discussed ranged from physical instability and ageing of red blood cells to the metabolism of senescence.

Citrus Fruits in Health and Disease, Second Edition, Published for the Medical Profession by The Florida Citrus Commission, Lakeland, Florida (Apply. *Noyes & Sproul, Inc., 444 Madison Ave., New York 22, N. Y.)* The brochure includes the most recent research from sources here and abroad. Particular emphasis is placed upon the importance of vitamin C to the teenagers, our poorest nourished age-group. It also includes a section on stress and the adaptation syndrome, covering of course the role of vitamin C in stress. The text is based upon 160 authoritative medical papers and was carefully reviewed before publication by James R. Wilson, M. D., formerly secretary of the Council on Food and Nutrition of the American Medical Association.

Psychiatry and Religion, MD's International Symposia No. 3. ($3.00. *MD Publications, 30 E. 60th St., New York 22, N. Y.)* Editorial introduction by Felix Marti-Ibanez, Werner Wolff, Chairman, and 12 noted participants. In the past most religious leaders contended that religion was the bulwark of the soul and that the ministration of the psychiatrist was not needed to strengthen those who suffered spiritual conflicts. The psychiatrist, on the other hand, considered religion merely as a beam of light to brighten up the dark night of the soul. This antagonism verging on hostility has lasted up to the present. Today, a more tolerant view and a broader concept has developed many groups devoted to "pastoral psychology" and societies for the scientific study of religion. This symposium came from the tenth meeting of the society for the study of religion.

The Dispossessed, by Geoffrey Wagner. ($3.50. *The Devin-Adair Co., 25 E. 26th St., New York 10, N. Y.)* In this tale the psychiatrists assume control over the mind, body, and soul of a young army captain wounded in battle in North Africa. His struggle to achieve his personality after the psychiatrists have denied it to him is a powerful theme treated in a manner at once satirical, witty and very timely. It is especially so in these days when "mental health" programs are being so inflated and pushed forward on all of us.

Tomorrow's Food, by James Rorty and N. Philip Norman, M. D. ($3.95. New revised edition. *Devin-Adair Co., 25 E. 26th St., New York 10, New York.)* This is a report by a competent science-journalist guided by a physician-nutritionist on the haste with which technological advances have been applied to our foodstuff with little or no attention to the effects of the consequent devitalization. It documents the diabolical role that the "hucksters" have played in making us believe, to the detriment of our health, that these devitalizing processes are in the name of progress. The exploitation of human health with white bread, enriched white flour, sugar and sweet drinks, margarine and vitamins, stand indicted.

Essential Urology, by Fletcher H. Colby, M. D. ($8.00. Third edition. *Williams and Wilkins, Baltimore 2, Md.)* Like the previous edition, this one presents the essential facts of embryology, anatomy, physiology and disease of the urinary tract. Basic principles are emphasized and the ever changing methods of treatment outlined. The confusing status of the recently acquired chemotherapeutic and antibiotic agents as applied to infections of the genitourinary tract have been clarified.

Roentgen Signs in Clinical Diagnosis, by Isadore Meschan, M. D. ($20.00. *W. B. Saunders Company, Philadelphia 5, Pa.)* The book presents the fundamentals of radiology rearranged on the basis of objective signs as seen in the x-ray picture. The text is organized to promote some idea of the limitations as well as the accuracy in x-ray diagnosis.

Understanding Human Behavior, by James L. McCartney, M. D. ($3.50. *Vantage Press, New York 1, N. Y.)* A defense of Psychonalysis which he insists can successfully guide an immature personality into a healthy mature existence.

"Eighty-seven patients with various infections of the skin were treated over a period of six weeks with [Signemycin]. Excellent or good results were achieved in sixty-seven, including eleven of twenty-two patients refractory to other antibiotics."

Lewis, H. H.; Frumess, G. M., and Henschel, E. J.: Rocky Mountain M. J. 54:806 (Aug.) 1957.

"Results of treatment with oleandomycin-tetracycline of 50 infections [mostly respiratory] due to resistant organisms and 40 infections [respiratory, skin, urinary infections] due to sensitive organisms are very encouraging. In some of these patients, [Signemycin] was lifesaving, and in others surgery was made unnecessary. This confirms other reports."

Shubin, H.: Antibiotic Med. & Clin. Therapy 4:174 (March) 1957.

Based on case reports documented by independent investigators in 26 countries abroad, the clinical response obtained with Signemycin in 1404 patients with a wide variety of infections was successful in 1329 patients: in 13 cases only was it necessary to discontinue therapy because of side effects.

Report on 1404 Cases Treated with Signemycin: Medical Department, Pfizer International. Available on request.

In 50 nonselected patients, Signemycin "...appears to be effective in the treatment of most general surgical infections, including virulent staphylococcus aureus infections. In some cases these infections had been clinically resistant to other antibiotics. The drug is apparently well tolerated."

Levi, W. M., and Kredel, F. E.: J. South Carolina M. A. 53:178 (May) 1957.

Of 50 patients with various infectious processes, 26 had not responded to previous antibiotic therapy. With Signemycin "Ninety-six per cent of the mixed infections were clinically controlled. . . . and in none of the cases was there any reason to discontinue the drug."

Winton, S. S., and Chesrow, E.: Antibiotics Annual 1956-1957. New York, Medical Encyclopedia, Inc., 1957, p. 55.

Signemycin in 79 patients with severe soft tissue infections: "The average response of these cases was excellent and inflammatory symptoms subsided with almost uniform rapidity....The magnitude and incidence of surgical intervention was reduced....Side reactions were minimal. . . ."

LaCaille, R. A., and Prigot, A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 67.

Five groups of patients (total 211) with acne were treated with one of five antibiotic agents, including Signemycin (55 cases). "The results were evaluated taking into consideration the usual response to such conservative conventional therapy and the rapidity of response." In 8 weeks, Signemycin rapidly attained and maintained the highest percentage of efficacy of antibiotic agents tried.

Frank, L., and Stritzler, C.: Antibiotic Med. & Clin. Therapy 4:419 (July) 1957.

In the treatment of 78 patients with tropical infections, some complicated by multiple bacterial contamination of present for years, Signemycin was found to be "...an exceptionally effective agent," requiring smaller doses and less extended periods of therapy than with the tetracyclines alone, and "caused no notable toxic reactions."

Loughlin, E. H., and Mullin, W. G.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 63.

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You and Your AMA

Some Highlights and Sidelights on the American Medical Association's Activities and Program

AMA PLANS INDUSTRIAL HEALTH CONGRESS IN MILWAUKEE

Maintaining high standards of health in industry will be a principal topic of consideration at the 18th annual Congress on Industrial Health to be held January 27 - 29 at the Schroeder Hotel in Milwaukee. Physicians, nurses, industrial hygienists, engineers and others interested in the field will attend the meeting sponsored by the AMA's Council on Industrial Health.

* * *

BUREAU OF EXHIBITS ANNOUNCES MAJOR PLANS FOR 1958

To reach more and more Americans with authentic up-to-date health information, the AMA's Bureau of Exhibits announces a number of major plans for 1958. First, a new exhibit titled "How We Breathe" will be ready for bookings after January 1, 1958. This exhibit will present a three dimensional model of the organs involved in breathing—the nose, pharynx, larynx, bronchial tubes and lungs. Other features include actual preserved human lungs; a unit to demonstrate the mechanism of breathing and the part played by the diaphram and rib cage, and a section showing the exchange of oxygen from the lungs to the blood and carbon dioxide from the blood to the lungs.

Two other exhibits also are well along in the planning stages for next year: (1) The brain and nervous system, featuring a human brain embedded in plastic and (2) the endocrine system.

Finally, small editions of the popular "Life Begins" exhibit are being built, incorporating most of the information in the large exhibit but displaying only one fetus embedded in plastic. Other fetuses in varying stages of development will be shown pictorially. This type of exhibit is extremely lightweight and should prove most attractive to those medical societies far away from Chicago.

* * *

SCHEDULE TWO "NOMENCLATURE" INSTITUTES IN '58

So popular have the Nomenclature Institutes been that the American Medical Association again plans to sponsor two more of these short courses during 1958. The first will be conducted March 31 to April 2 at Tulsa, Oklahoma. The second will be held in July in Boston. These three-day meetings are planned by the AMA as a special service to medical record librarians and others working with the *Standard Nomenclature of Diseases and Operations* in the hospital, clinic or doctor's office.

* * *

WINTERTIME FUN AND THE PICTURE OF HEALTH

How to live sensibly and still have a good time in cold weather is the way of life outlined in a new series of radio transcriptions the AMA's Bureau of Health Education will have available for use by medical societies early in December. In the 13-program series "The Picture of Health," brief dramatizations of typical family life are presented—illustrating how far open the bedroom window should be at night or the kinds of food one should eat to stay healthy.

Other subjects covered in the series include: general winter exposures; snow and ice hazards for pedestrians; frostbite and chilblains; skiing hazards; diet; driving; household procedures (such as temperature and moisture in the room). Dr. W. W. Bolton, Bureau associate director, serves as medical consultant.

* * *

1957 SURVEY OF COUNTY MEDICAL SOCIETIES

Replies to the questionnaires sent to county medical societies concerning their activities and programs have been tabulated and published in booklet form by the AMA's Council on Medical Service. The booklet—"1957 Nationwide Survey on County Medical Society Activities"—contains information on types of county medical society programs (such as emergency call systems or grievance committees), fee schedules, life insurance, attendance at meetings and dues. Copies will be sent to all county and state medical societies. Additional copies may be secured from the Council.

* * *

AMA TO CO-SPONSOR SYMPOSIUM AT AAAS MEETING

A program on normal and abnormal aspects of the skin will be sponsored jointly by the AMA's Committee on Cosmetics and the Society for Investigative Dermatology December 28-29 during the 124th annual meeting of the American Association for the Advancement of Science in Indianapolis. The two-day symposium entitled "The Human Integument—Normal and Abnormal" will be presented before the medical sciences section of the AAAS. Further details may be obtained by writing directly to the Committee on Cosmetics.



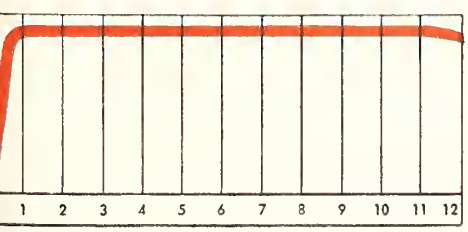
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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

CONFLICT OF WEALTH AND WELFARE

That time-old question of how to reach a balance between welfare and wealth is touched on in a document prepared by a firm of consulting economists which discusses the social and economic implications of government welfare programs.

The report recently released was drafted at the request of the Canadian Chamber of Commerce and Canadian Life Insurance Association and refers specifically to Canadian health programs. The following paragraph of the long report is of particular interest:

"A possible conflict between two desirable social objectives (wealth and welfare) obviously poses difficult problems of choice. . . . The main conflict posed by these two objectives is that an excessive concern with welfare expenditures may stunt the wealth-creating capacity of the community. On the one hand, taxes beyond a certain level tend to dry up sources of saving and investment and reduce incentives to strive for higher personal income, particularly at the executive level. On the expenditure side, the expansion of welfare benefits tends to narrow the scope of personal responsibility and dull incentives for personal advancement on the part of recipients. When welfare policy comes to have precedence over policies aimed at higher national productivity and output, the society concerned may be thought of as trying to eat its cake before it has it. Wealth must therefore come before welfare because in the long run it is productivity and not the degree to which income redistribution is arranged by legislation that determines real income."

YOUNG GOP TAKES A LOOK AT U. S. HEALTH PICTURE

Interesting for two reasons is that part of the platform of the Young Republican National Federation relating to health and welfare, adopted at the organization's convention in Washington, D. C.

First, the newly elected chairman of the Federation is the Hon. John M. Ashbrook, Johnstown, Ohio, Licking County's representative to the House of Representatives of the current Ohio General Assembly. As Ohio physicians already know, Mr. Ashbrook was a member of the House Health Committee and that his record on medical-health questions was a bullseye. That the Federation will be well managed with him in the saddle, goes without saying.

Second, the Federation's statement on medical-health matters indicates that the youngsters in the GOP ranks may be more conservative and sensible than some of their elders, who should know better. Excerpts from the statement follow:

"Health statistics reflect the remarkably high level of health of the American people. Our life expectancy continues to increase; the more serious communicable diseases, including poliomyelitis, are being brought under control. Unexcelled sanitation programs have produced safe food and water; advances in industrial hygiene have brought protection from industrial hazards; research in medical science has pushed nearer the day when successful prevention or treatment of cardiovascular diseases and cancer may be achieved; voluntary health insurance of many different kinds has been made available through competitive enterprise that is cushioning the shock of the cost of illness to the majority of our people.

"To maintain these advances and promote continuing progress we pledge our support to the healing professions in their enterprising efforts to promote better health for all Americans.

"We support the free-enterprise system in health because of its proven ability to achieve its objectives. We oppose all efforts to impose Government control over the medical profession and other healing arts through compulsory health insurance or any other proposal that seeks that end.

"We endorse Federal financial support of research in health as long as such funds can be used with maximum efficiency."

THE PRESS, MEDICINE AND THE PUBLIC

Robert Clark, science writer for the *Louisville Courier Journal*, was one of several panelists who discussed medicine and the press at the AMA Public Relations Institute in Chicago. When he returned home, he wrote a story about that phase of the institute program for his paper. This article served as the basis for an editorial in the same paper, "Press and Medicine Both Serve the People."

The editorial, which advocated mutual tolerance and mutual effort between medicine and press, contained several pertinent paragraphs:

"The two professions—medicine and journalism—have some notable points of similarity. Both are concerned with important functions of human life. Doctors strive to preserve and restore human health. . . . Journalists deal with the health of human minds in a democracy by trying to keep them adequately informed.

"Both professions are practiced by men and women who are passionate believers in their calling. Here is perhaps the root of some misunderstanding. A doctor believes that all must recognize the nobility of his profession. A journalist is just as convinced that the

satisfaction of the people's right to know is a duty of a high moral order. Such pride can lead to arrogance on both sides. The practitioners of both professions sometimes fail to explain their actions fully to each other or to the public, because they forget that any explanation is necessary. . . .

"At one point, the two professions diverge widely. Medicine has an old tradition of silence. Professional secrecy is enjoined in the Oath of Hippocrates, to which doctors subscribe. The journalist, on the contrary, is pledged to giving the public 'all the news that's fit to print.'"

Admitting "some trouble between medicine and the press" over faulty news reporting, the editorial explained how leading papers are recognizing the problem by training special medical and science writers on their staffs.

"It is surely to the interest of the medical profession to help these writers do their jobs as well as possible," the article said, adding: "Even doctors who find publicity distasteful and undignified in their personal lives must recognize that public relations for their profession is a necessity of the modern world."

IS IT ETHICAL OR UNETHICAL?

Is there an ethical question involved when a physician wishes to patent a surgical or diagnostic instrument he has developed?

Here's what the Judicial Council of the AMA has to say on the matter:

"It is not unethical for a physician to patent a surgical or diagnostic instrument he has discovered or developed. Our laws governing patents are based on the sound doctrine that one is entitled to protect his discovery. Medicine, recognizing the validity of our patent law system, accepts it, but in the interest of the public welfare and the dignity of the profession insists that once a patent is obtained by a physician for his own protection, the physician may not ethically use his patent right to retard or inhibit research or to restrict the benefits derivable from the patented article. Any physician who obtains a patent and uses it for his own aggrandizement or financial interest, to the detriment of the profession or the public, is acting unethically."

DON'T LEAVE NARCOTICS IN YOUR AUTO

Cincinnati Academy of Medicine has been compelled to issue the following warning to its members, so it would behoove physicians all over the state to comply with the recommendations voiced:

"The Police Department is experiencing considerable difficulty with addicts who are breaking into vehicles that bear the physicians' insignia or physicians' license plates. Since police raids have resulted in the closing down of narcotic rings, narcotic users are obtaining their supplies by breaking into physicians' automobiles and taking their bags for the purpose of obtaining narcotics for self-use. Please lock your car before leaving it parked on the street or parking lot. The safest place for a medical kit is in the trunk of your automobile. The police urgently request the co-operation of all physicians in Hamilton County. It is a bad practice to leave your automobile unlocked while your medical kit is either on the seat or floor of your automobile."

WHAT'S THE IMMUNIZATION SITUATION IN YOUR AREA?

According to a recent report published in *The AMA Journal*, nearly half of the new students entering the University of Minnesota in one year were not immune to diphtheria despite a long-time statewide program of diphtheria immunization.

Obviously, this indicates that complacency with regard to diphtheria immunization is out. There may be a need for promotion of routine immunization procedures by personal physicians in many, many areas. How does yours stack up?

THE DOCTOR AND HIS AGED PATIENTS

A physician needs to be more than just a doctor to an aging patient; he must be a "guide, philosopher, and friend," according to Dr. Wingate M. Johnson, Winston-Salem, N. C.

Pointing out that the physician should help foster the correct attitude of the aged person, Dr. Johnson added: "Many of the most unpleasant traits of adolescence and old age have a common basis—the desire to belong. . . . The adolescent wants to achieve recognition as a useful member of society, the oldster wants to retain that recognition. The doctor can help the older patient's morale by showing a genuine interest in him and his environment."

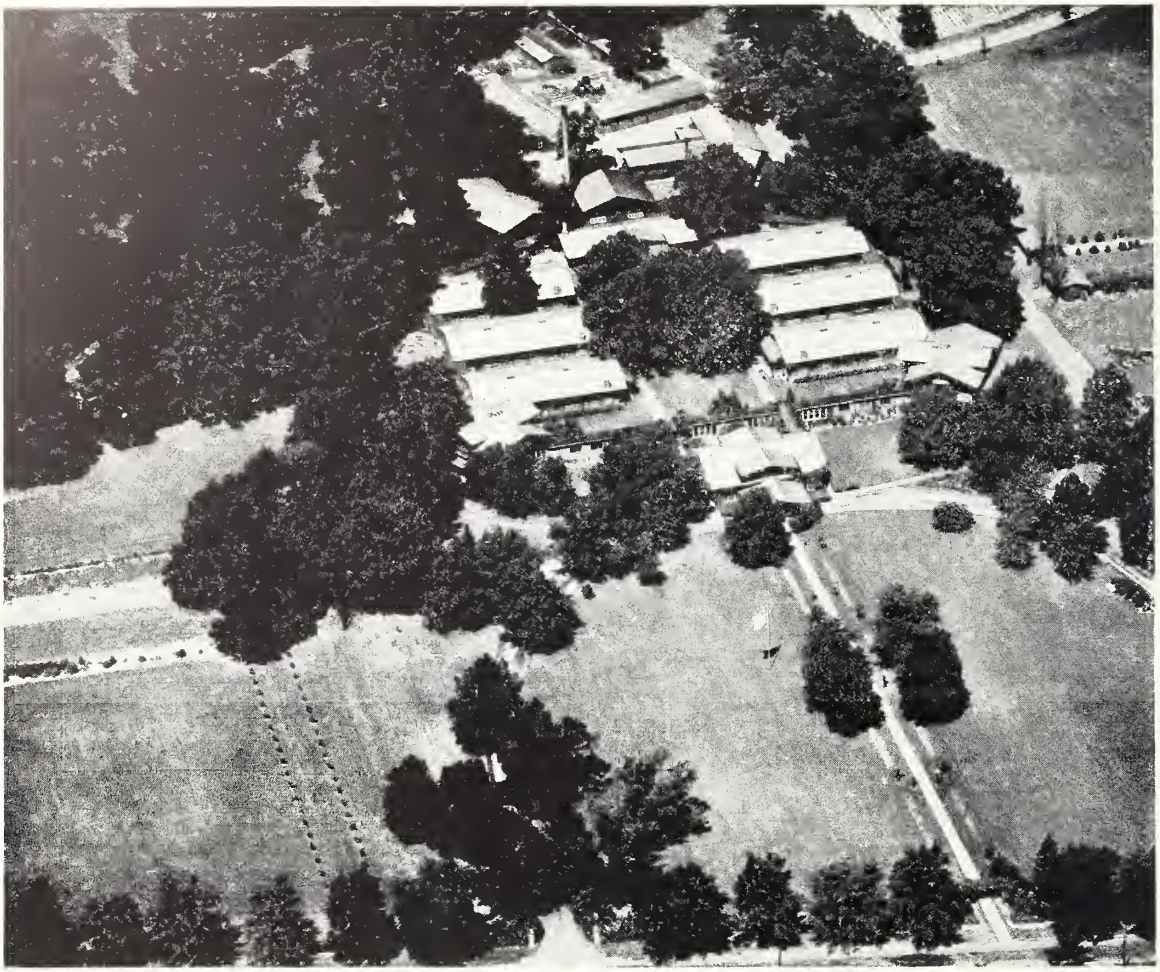
Keep this advice in mind as you see your older patients.

PASSWORD TO MEDICAL SOCIETY BRASS HATS

In taking over the presidency of the Cincinnati Academy of Medicine, recently, Dr. George X. Schwemlein made one particular observation which rings the bell.

Answering a criticism which is voiced occasionally that "medical organization is run by a clique," he said:

"You need to know the password to be admitted to the inside clique of organization brass hats. That password is a four-word slogan. Whisper it in the president's or secretary's ear. The four words are: 'I want to work.'"



AERIAL VIEW FROM FRONT

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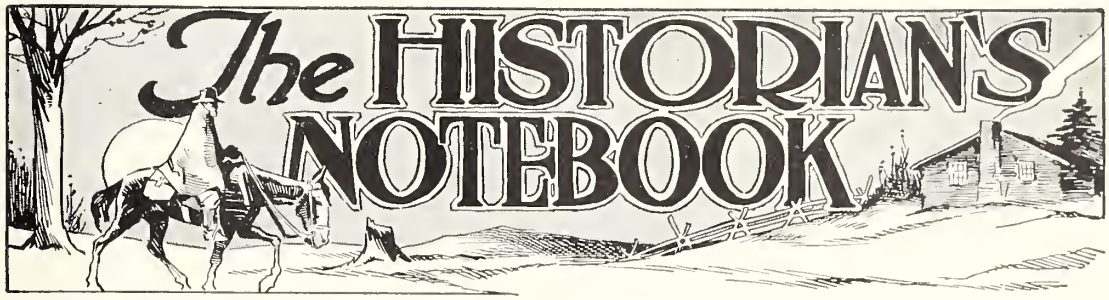
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PHILIP C. ROND, M. D.

PART II

(Concluded from November Issue)

BY 1850 it appears there were no longer any distinct chairs of Insanity in any medical college, according to Edward Mead, who was editor of the *American Psychological Journal*, which was published in only six editions from January, 1853, to November, 1853. Dr. Mead, who apparently was the second professor of psychiatry in the United States[9] at the Cincinnati College of Medicine and Surgery, which was founded in October of 1851, stated in the final edition of his *American Psychological Journal* that "Dr. S. M. Smith, of the Starling Medical College, having sometime since been transferred to the Chair of Theory Practice, we believe there is now no distinct Professor of Insanity. This is a serious defect in the course of instruction provided by medical colleges." Incidentally, Dr. Mead had hoped that his *American Psychological Journal* would "become for the west what the *American Journal of Insanity*, originated by the late Dr. Brigham, had become for the eastern portion of the United States."[10]

COMMUNITY CONSCIOUSNESS

Dr. Smith served his community and his state in a manner which was exemplary beyond all doubt. From 1847 on, he seems to have led a very active medical and community life. In 1859, Governor Salmon P. Chase appointed him Surgeon-General of the State of Ohio, which post he also held under Governors Dennison and Tod. He was appointed by Governor Chase a trustee in the Central Ohio Lunatic Asylum, and served in this capacity for 18 years.

He was a sympathetic man, and his kindness was known to everyone. He was a sagacious and resourceful practitioner. He was an eloquent speaker, a skillful diagnostician and therapist. He was a most ardent abolitionist and spoke in unmeasured terms against the institution of slavery and professed a great liking for Negroes, among whom he had many friends. His manners were singularly pleasant and his mode of making excuses for the shortcomings of others was at times very amusing.

Dr. Smith was one of the original anti-slavery men of the State of Ohio, and he never lost an opportunity to express his dislike for the "divine institution." He was one of the first in this part of the country to join the Republican Party, and he gave much of his time and money to assist in forwarding its aims. He was very familiar with the Bible, and was seldom at a loss for a quotation therefrom. He knew Shakespeare equally well, liked Scott and Longfellow and had a great fondness for Isaac Walton.

MANY AND VARIED INTERESTS

The lectures he gave were very concise and clear. His clinical lectures were especially good, and no one was surprised at his popularity with the students, who never "cut" his hour. He allotted considerable time to general practice, but was also an enthusiastic and very successful obstetrician, and was the first in Columbus to administer chloroform to a woman in labor.

With all his interests he also continued to be known for his psychiatric ability. The announcement concerning the opening of the Wil-

The Author

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Submitted June 17, 1957.

loughby Medical College of Columbus in 1847 stated the following, "Professor Smith will give a series of lectures on the nature and treatment of insanity, and those diseases leading to it, for which his connection for several years with one of the best hospitals peculiarly qualifies him." In 1870, four years before his death, the *Transactions of the Ohio Medical Society* show that he was appointed to a special committee to examine the Plea of Insanity in Cases of Homicide.

During the Civil War he was a member of the Board of Examiners of Army Surgeons at Camp Chase, located on West Broad Street in Columbus, Ohio. He served as Surgeon-General of the Ohio troops during the war, and after the war was appointed a member of the Board of Examiners of Pensions. He was also physician for the State School for the Deaf.

WORDS OF WISDOM

Dr. Smith was the twenty-fifth President of the Ohio State Medical Society (Association). He held office in 1869-70. He presided at the twenty-fifth, or Silver Anniversary Meeting of the Society which met in Cleveland June 14-16, 1870. In his excellent address as departing President of the Society, Dr. Smith reveals himself as the thinking, capable man he was. The speech showed considerable foresight into the medical field.

In this address Dr. Smith directed himself to what it was in the medical profession at that time which impeded its progress. He noted, first of all, a "want of precision in language," which interfered with communication between medical men then, as it does now. He apparently was appalled by the use of words for the purpose of obscuring meaning or just to use the word. The second thing that he disliked was "a want of accuracy and care in observation and experiment." He asked, "Where did you observe, how did you observe and what right had you to observe; what precautions did you take against deception, and what proof do you have that you are not deceived?"

More important than all others, however, Dr. Smith felt that the want of the genuine love of truth was the most disturbing factor in the medical man of his day. He asked what happened to the zeal of the medical student when he departed medical school, and then went on to answer in the following manner: "His zeal abates, his application flags, his energies fail, his ardor for truth cools and he falls into the rut of routine; or seduced by the glare of untried fancies that are constantly arising along his path, he follows with an unstable fitfulness the phantom of the hour."

He goes on to say, "Is there any community of a dozen or more physicians that does not have a well-defined representative of the two (following) extremes: the one iterating, reiterating day after day, month after month, yes, year after year the same medicines in the same questionable combinations for half the diseases, with their diversified character, grade and stage that occur in their practice; the other rarely adhering to one course of treatment in the same disease for half a dozen cases in succession, or for as many successive months."[11]

In 1865 Dr. Smith purchased an interest in the *Ohio State Journal* (still being published daily). He owned it jointly with his son-in-law, General James M. Comly. The latter had been an editor of the paper for several years. Dr. Smith disposed of his interest in the *Ohio State Journal*, of Columbus, Ohio, in the year prior to his death. In 1871, he was a candidate on the Republican ticket for State Senator. In 1872 he attended the International Prison Reform convention in London as an official delegate.

A EULOGY

Dr. Smith died at 1:20 p. m. on November 30, 1874, in Columbus, of a cerebral hemorrhage at the age of 58. He was eulogized by the Columbus Academy of Medicine on his death in the following words,—"The medical profession has suffered the loss of one of its highest ornaments, the community an upright and worthy citizen, and the suffering and sick a sympathetic and faithful friend." The Academy resolved to attend his funeral in a body. He was memoralized by the Starling Medical College faculty and by the student group. He was buried in Greenlawn Cemetery in Columbus.[12, 13, 14, 15, 16]

In conclusion, it would seem that because Dr. Smith did not publish anything to gain national attention Albert Deutsch in his book,[17] *The Mentally Ill in America*, overlooked him when he stated, "It appears no systematic course on nervous and mental diseases was given anywhere in America from Benjamin Rush's death in 1813 until 1867, when William Hammond was appointed Professor of Nervous and Mental Diseases at Bellevue Hospital." It appears that Dr. Smith gave his systematic course of lectures for at least three years and perhaps longer (1847-1849).

Dr. Samuel Mitchel Smith is a matter of civic pride for Columbus and all of Ohio medicine, but he is claimed by psychiatry as being its first medical college lamplighter.

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JONATHAN FORMAN, M. D., *Editor*

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Asst. Managing Editor

The Present Status of Major Arterial Grafting

ALFRED W. HUMPHRIES, M. D., VICTOR G. deWOLFE, M. D., and FAY A. LeFEVRE, M. D.

ARTERIAL grafting, although still in its infancy, has been done for a sufficient period of time to have become established in the surgical treatment of disease, although the scope of its application is not fully clarified.

INDICATIONS FOR GRAFTING—ANEURYSMS

Certain of the indications for grafting are becoming more clear as time goes on. All abdominal aneurysms should be excised and grafted unless the patient has concurrent disease of a major nature that would minimize his life expectancy; heart failure, metastatic cancer or other conditions of this magnitude. The danger inherent in aortic aneurysms is rupture, either gradual or acute. The incidence of rupture at some time during the progress of the natural history of the aneurysm is so high and the operative mortality so low that we feel the only reasonable philosophic approach is one which assumes that the presence of an abdominal arteriosclerotic aortic aneurysm is ipso facto indication for its removal and replacement with a graft.

Aneurysms in the popliteal area should also be grafted when present. The complications here are several. They can rupture, usually with the formation of a large false aneurysm, but not death. Emboli may be released from the lining wall of the aneurysm with involvement of the smaller terminal vessels in the foot and toes. They may thrombose and obliterate the ostea of all the geniculates resulting in gangrene of the foot unless circulation is re-established in a short period of time.

From the Departments of Vascular Surgery and Cardiovascular Disease, The Cleveland Clinic Foundation, and The Frank E. Bunts Educational Institute, Cleveland, Ohio.

Submitted June 13, 1957.

The Authors

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INDICATIONS FOR GRAFTING—ARTERIOSCLEROSIS OBLITERANS

The indications for grafting in arteriosclerosis obliterans are not so clear cut. However, through experience with 350 grafts we have established a tentative approach. There are two major indications for grafting an occluded arteriosclerotic vessel. One is for the relief of symptoms and the other is an attempt to prevent or at least slow down progression of the disease. The successful grafting of an occluded vessel with re-establishment of blood flow will in the vast majority of cases relieve the complaint of intermittent claudication. Nevertheless we have seen instances in which even full restoration of cir-

culation does not totally relieve claudication, this being particularly true in the case of an aortic graft where one internal iliac has been tied off and collateral circulation from the other side is not adequate. Such a patient may present a minimal degree of hip claudication despite the presence of full foot pulses.

We also feel that the restoration of flow tends to minimize progression of the disease in the sense that they do not develop a second, higher block as frequently. We have seen many patients with a single block, particularly in the femoral artery, go on at a later time to develop secondary blocks at a higher level, usually external iliac or common iliac. It would seem logical to suppose that in the presence of a roughened vessel with some arteriosclerotic plaquing on the walls that the slower blood were to flow the greater would be the likelihood of increasing surface deposition of blood elements and the eventual formation of a total clot. The operative cases have shown much less of a tendency toward a secondary higher block than those patients treated conservatively.

Arteriosclerosis obliterans is a progressive disease. In over 800 patients studied, only a few have not shown some evidence of progression over the course of months or years. Therefore we feel that if a patient's symptoms are definitive, and particularly if his claudication is increasing, a graft should be done while it is still possible. We have waited too long on some patients and their blocks have extended to a point where they became technically impossible.

IMPORTANCE OF ANGIOGRAMS

There are, however, patients with arteriosclerosis obliterans who are not candidates. We feel, in contradistinction to some other workers in the field, that it is essential to obtain adequate angiograms prior to contemplating a graft. Too many times in the past we have been unpleasantly surprised upon completing a graft to find there was a second occlusion at a lower level or an inadequate exit flow. For a graft to remain open the limb must be capable of taking out of the distal end of the graft as much blood as is put in at the proximal end. It is always easy to obtain an adequate flow into the graft since one can go as high as is necessary to reach a good supply. If on the other hand the distal vessels in the leg are sclerotic or occluded and collaterals are poor, back resistance develops and prevents the same amount of blood from going out of the graft as comes in. With decreased flow rate, back currents and eddies develop and thrombosis of the graft either primarily or within the first few days can occur.

We do full angiograms on all patients exclusive of aneurysms, in whom we contemplate a graft. If the exit flow in the distal part of the leg is not adequate, we believe the graft should not be attempted. Even with the most careful of techniques it is impossible to approach the femoral artery in one or more places without cutting some collaterals in the process. If the graft is doomed to failure from the beginning, the approach to the vessel alone will succeed in making the patient worse in a certain number of cases.

Diabetics with arteriosclerotic occlusion of the femoral artery whose only complaint is intermittent claudication are probably not candidates for grafting. The progression of arteriosclerosis obliterans is much faster in diabetics and the grafts that we have done in the femoral artery in diabetics have been quite unsuccessful. This is not true of the larger vessels within the abdomen.

GRAFTING MATERIALS

In our particular series we have used only lyophilyzed homografts sterilized in ethylene oxide. The material has been obtained from several sources and is processed as a community service, the vessels being available to anyone interested in doing an arterial graft. Our experience with other than homografts has been limited to two cases, one with Nylon and one with Teflon. Both patients were poor candidates for any type of surgery and both were failures. There are two reasons why we have elected to utilize homografts other than the fact that they have been available in sufficient quantity to meet the demand. First, the elasticity and perfect shape of these vessels, particularly the bifurcations, is such that they make the best mechanical replacement available. Second, it is felt desirable to have at least one series of reasonable size that is limited exclusively to one particular replacement material for possible future comparison.

There are many prostheses available. Perhaps the most satisfactory materials according to the recent report by Deterling are Dacron and Teflon. Many synthetic replacements have been successfully done. The highest success rate with artificial prosthesis has been in the larger diameter vessels, particularly the aorta and the common iliac arteries. In the smaller vessels such as the external iliac or femoral the incidence of success definitely decreases. To quote from Deterling's report[1] expressing the opinion of a subcommittee of the Society for Vascular Surgery, "although equivalent results have been achieved in the arteries of dogs with synthetic replacements and homografts, at the present time synthetic prostheses seem to be less satisfactory than tissue grafts in the peripheral arteries of man especially in the treatment of occlusive disease. Failure by thrombosis appears to be related to the diameter of the vessel and to the extent and nature of the disease process. It seems evident that more work is needed for the development of more satisfactory synthetic replacements for peripheral vessels and that there is still a clinical need for tissue grafts." However, it is obvious that the final answer is going

to have to lie in either the development of a satisfactory synthetic prosthesis or some nationally organized method of obtaining homografts, for the current supply of homografts is not adequate to fulfill the need.

SYMPATHECTOMY AND THROMBOENDARTERECTOMY

Sympathectomy has a definite place in the treatment of occlusive arterial disease. However, we feel its use is limited. It may increase skin circulation and so lower the level of an amputation. In some of the more borderline grafts it is possible the sympathectomy, preceding the graft by several weeks, may enhance the peripheral vascular bed just enough to convert an inadequate exit flow to one that is satisfactory. We are not entirely sure of this second indication at the present time but it is being used in certain isolated instances. In unusual instances, when the collateral pattern is just short of being adequate, sympathectomy may relieve the claudication.

Thromboendarterectomy has received considerable attention, particularly on the West Coast where it is being used to a fairly extensive degree. Thromboendarterectomy will work in a certain number of cases. It is our personal opinion that it will not work as frequently or as well as will the replacement of the vessel with a homograft, and this becomes increasingly true the smaller the caliber of the vessel involved. Endarterectomies done in the aorta will be successful in a fairly high percentage of cases. However, it leaves a weak and rough wall and we think offers more dangers, both of rupture and of secondary thrombosis, than would the use of a graft. Since re-establishment of a smooth lining, whether it be intima or organized thrombus, involves the deposition of tissue elements upon the rough surface left by the endarterectomy, there must be diminution of lumen size following surgery. In an aorta this is probably not particularly significant, but in the femoral vessels such narrowing of the lumen may well result in secondary thrombosis.

RESULTS

The results of grafting over the past four years have been encouraging. The morbidity and mortality percentages year by year have steadily decreased and facility in accomplishing the grafts has increased. We have also found that the majority of occlusive disease and all of aneurysmal disease can be grafted if one does not hesitate to go far enough to find a usable vessel distally. The highest success rate is in the elective aortic group and the lowest success rate in the non-elective aneurysms. We should specify that our definition of elective is any case that is done at a time selected by the operator based on convenience, whereas a non-elective case is one that must be done as an emergency. Therefore, the non-elective are either badly leaking aneurysms or progressive occlusions that have gone on to a point where a foot is either pre-gangrenous or gangrenous. Under this definition a non-elective is a hopeless cause and any salvage rate in this group is attributable to the procedure itself. At this time the continuing success rate in the elective cases is 86 per cent and that of the non-elective cases is 65 per cent.

CONCLUSIONS

In conclusion it may be stated that although the bulk of future knowledge regarding arterial grafting has yet to be learned, the procedure so far has been satisfactory enough to justify its continued place in the surgical armamentarium, and to have become the treatment of choice in arterial occlusive or aneurysmal disease when technically feasible.

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Ozone Poisoning is Subject Of Renewed Interest

Ozone poisoning has become a subject of renewed interest because of the recent increase in concentration of it in city air, the high content of it in the atmosphere at high altitudes now being explored by man, and the generation of the gas during the use of electrical welding apparatus. As Haagen-Smit so well demonstrated the nitrogen dioxide and hydrocarbons of automobile exhausts react to form ozone in the presence of sunlight.

Between the hours of 10 a. m. and 3 p. m. the ozone concentration often reaches 0.2 to 0.3 parts per million (p.p.m.) for periods of from two to four hours. Several times a year 0.5 p.p.m. is reached in the Los Angeles atmosphere, and this is the signal for the "first alert" by the Air Pollution Control District; at least once, the content rose to 0.9 p.p.m. for a few minutes. Rarely does a concentration of 0.5 p.p.m. or higher last more than two hours. Present information indicates that except for exposures of longer than four hours, these concentrations are harmless; but concentrations above 1 p.p.m. inhaled for more than four hours are probably hazardous.

Animal experiments by Stokinger and by Mittler and co-workers showed that whereas 1 p.p.m. for four hours causes no observable harm in animals at rest, it may cause death when animals are moderately exercised. Mittler also reported that there is no influence on growth of animals that are exposed to 1p.p.m. daily for less than four hours a day. Human subjects exposed to 1 p.p.m. at rest showed no evidence of injury, but at 2 p.p.m. there was definite evidence of decreased pulmonary efficiency. At 8 p.p.m. for one hour, there was a loss of 45 per cent of lung capacity.—Clinton H. Thienes, M. D., Pasadena: *California Med.*, 87:135, September, 1957.

Intratracheal Goiter

MARVIN S. FREEMAN, M.D.

PRIMARY tracheal tumors are distinctly rare. Only 546 cases of all types were found by Gilbert and associates[2] in their survey as of August, 1952. Even more uncommon are such tumors when they are composed of aberrant thyroid tissue.

INCIDENCE

Authorities differ as to the number of intratracheal goiters which have been found. The first reported case was by Von Ziemssen in 1875. Cooper[1] quotes Maier as having collected 28 such cases in 1922. McGavack[4] mentions a study by Thoren in 1947, in which he found 79 cases in the world literature since 1875. Gilbert (et al.) found only 32 intratracheal goiters in a survey extending from 1898 to 1952. Since then only an occasional case has been reported, mainly from continental Europe. It may be safely assumed that today the total number of known cases is well under 100, and that intratracheal goiter comprises between 6 and 7 per cent of all endotracheal tumors.

ETIOLOGY

Several theories as to the cause of intratracheal thyroid are currently held. During the process of differentiation in the fetus small fragments of primitive thyroid may be enclosed in the respiratory tract. The developing thyroid may penetrate the wall of the larynx or trachea at some weak spot and subsequently develop in the new site. Finally, it is thought that aberrant tissues may be formed as the result of neoplastic invasion of low grade malignancy.

DISTRIBUTION

It is interesting to note that aberrant thyroid tissue may be enclosed in structures other than the respiratory tract. Lingual, sublingual, prelaryngeal, and intrathoracic goiters have been rather widely recognized. Not so well known is the occurrence of such tissue in the ovaries, vertebral column[3] and maxilla. McGavack[4] points out that the left side of the trachea is involved four times as often as the right, and that majority of the tumors occur posterolaterally in the caudal portion of the larynx. The condition occurs three times more frequently in women than in men.

Progression of symptoms of intratracheal goiter is very gradual, extending over a four to five year period. The earliest and most common symptom is dyspnea, which may be accompanied by a feeling of a lump in the throat. Later an irritating cough or hoarseness may develop, followed by stridor when encroachment of the tracheal lumen occurs. It was at this stage that the patient whose case is here reported was first seen.

Submitted November 3, 1956.

The Author

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CASE REPORT

The patient, a 41 year old, white female was admitted to Lutheran Hospital, Cleveland, Ohio, on November 9, 1951, with a chief complaint of difficulty in breathing. History revealed that her complaint was of two to three years' duration, gradually progressive, and had become markedly worse in the 48 hours preceding admission. The day after admission marked laryngeal stridor became apparent and emergency consultation was requested.

The past history noted a thyroidectomy performed 17 years earlier, and that medical consultations in the past three years had ascribed her difficulty in breathing to "nerves."

On examination, the patient was found to be a well developed and well nourished white female in obvious respiratory distress. The cardinal signs of laryngeal obstruction were



Fig. 1. Endotracheal Thyroid. Photograph shows radiographic appearance of the subglottic mass.

present. These were confirmed by mirror laryngoscopy which showed impairment of movement of the right arytenoid cartilage and vocal cord. Beneath the latter, swelling of the trachea to the point of occlusion could be seen. The remainder of the physical examination was not remarkable except for a well-healed thyroidectomy scar. The routine laboratory work was within normal limits.

The patient was taken to surgery where it was found that the tracheal occlusion had progressed to such a degree that only a No. 3 Jackson bronchoscope could be passed. Tracheotomy was done over the bronchoscope with some difficulty due to the dense scar tissue in the anterior portion of the neck. The respiratory distress was promptly relieved.

Two days later, an anterior commissure laryngoscope demonstrated a smooth rounded 2 cm. subglottic mass arising from the right lateral wall of the trachea extending to the left lateral wall. The mucosa overlying the mass appeared normal. Figure 1 shows the radiographic appearance of the subglottic mass. Biopsy specimens of the tumor were reported as normal thyroid tissue.

Ten days later, exploration of the neck was carried out in an attempt to explain the presence of normal thyroid tissue within the trachea. Only moderate hypertrophy of the normal residual thyroid gland was found. The trachea, including the cricoid cartilage, was then opened and a 2½ cm. tumor mass was seen on the right posterolateral tracheal wall. The mass was oval in outline with its long axis parallel to the axis of the trachea. Submucosal dissection of the tumor was performed leaving a well developed fossa in the cricoid cartilage into which the overlying mucosa was draped. The wound was closed in the normal manner.

The patient's postoperative course was entirely uneventful and direct laryngoscopy ten days later revealed a normal tracheal lumen.

Follow-up examinations have revealed no evidence of recurrence or stenosis after a five year period. Tracer I studies in 1954 show the presence of normal functioning thyroid tissue in the thyroid area.

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Controversy as to Treatment Of Toxic Nodular Goiter

There is controversy among clinicians as to the desired treatment of toxic nodular goiter although perhaps the majority of them believe the use of radioactive iodine alone is not justifiable as in the treatment of toxic diffuse goiter. Even though the radioactive iodine therapy would reduce the thyrotoxicity satisfactorily, the patient still would be left with a nodule. Most clinicians consider the danger of development of malignancy in this nodule is too great to justify leaving it in.—Warren H. Cole, M. D., Chicago: *Texas State J. Med.*, 53:689, September, 1957.

KEEPING UP WITH MEDICINE

• THE CONCEPT of a safe rate of radiation does not make sense if one is concerned with genetic damage. It is the total accumulated dose to the reproductive cells of the individual from the beginning of his or her life up to the time the child is conceived.

* * *

• PATIENTS with acne respond to treatment with a broad spectrum antibiotic in most satisfactory manner in a month or so—often within two weeks.

* * *

• PATIENTS having a congenital heart lesion with a superimposed pulmonary disease, or a normal heart with severe involvement of the bronchopulmonary tree (pancreatic fibrosis, bronchiectasis, bronchiolitis, congenital lung cysts, severe atelectasis or pneumothorax, or severe deformities of the thoracic cage), should be carefully watched and evaluated.

* * *

• GIRLS tend to shed deciduous teeth about five months earlier than boys, although the sequence in which the teeth are shed is identical in both sexes.

* * *

• WHEN SENSITIZATION to one sulfonamide is known to exist, cross-sensitization to other sulfonamides can occur, as well as cross-reactions to certain topical anesthetics, paraphenylene, para-aminobenzoic acid, etc. Few physicians dare use sulfa compounds topically anymore but we all use them systemically. Then, too, the carbonic amhydrase inhibitor Diamox® which is now widely used in glaucoma and edema due to congestive heart failure and certain new compounds which have an antidiabetic effect on oral administration are all sulfonamides and must be considered with respect to cross-sensitization.

* * *

• IT HAS BEEN SHOWN that egg albumin, thyroglobulin, fish protein, and milk can be absorbed into the blood stream without first being broken down by digestive enzymes. Then too, undigested egg white administered to dogs by way of a stomach tube can be detected in the thoracic duct lymph and when instilled into the nose can be found in the cervical lymph nodes.

* * *

• ADRENOCORTICAL steroid hormones do not inhibit the noxious stimulus which initiates the chain of the reactions which we call inflammation, but rather exert their antiphlogistic effect by interrupting the chain of cellular destruction that is triggered by the initiating stimulus.

* * *

• THE HIGHER incidence of chronic eczematoid eruptions of the hands of women allergic to nickel may be accounted for by the possible effects of the detergents in enhancing the reaction-producing capacity of potential allergens—in this case, nickel.—J. F.

Clinical Evaluation of Newer Anti-Inflammatory Steroids, II—A Comparative Study In 350 Cases with Prednisolone

M. M. SZUCS, M.D., SAMUEL PETRAGLIA, M.D., and M. C. GALOSE, M.D.

SINCE Bunim, Pechet and Bollet[1] first tried prednisone and prednisolone clinically in patients with rheumatoid arthritis in 1954, we can safely judge that today these corticosteroids are highly useful drugs in a wide range of complaints. Shortly after this work appeared, Spies[2] reported on the use of prednisone and prednisolone as therapeutic agents.

A multitude of additional reports have now been recorded in the medical literature pertaining to the clinical application of these "Anti-Inflammatory" steroids. This report is an extension of the original work of Szucs[3] on the combined use of prednisolone-aspirin therapy in the treatment of arthritis.

The mode of action of these steroids remains unknown at present and although these compounds (prednisone and prednisolone) have been found to exert a profound suppressive influence on the active manifestations of the disease, there is little or no real effect on the underlying disease process. The antirheumatic effect, if any, is at most secondary to a generalized anti-inflammatory process which has been obtained in a large number of inflammatory processes that include rheumatoid arthritis, rheumatic fever, the collagen diseases in general, gout and others.

CLINICAL CASES, METHODS AND MATERIALS

(A) Clinical Cases:

Our evaluation of this form of therapy extends over a period of six months to one year in a total of 350 cases and covering three states. These cases were clinically divided into the following groups: (1) Rheumatoid arthritis; (2) Osteo-arthritis; (3) Miscellaneous (soft tissue) including fibrositis and bursitis; (4) Algias, including acute arthralgia of soft tissue and myalgia; (5) Arthritis of gout; (6) Collagen diseases; (7) Traumatic arthritis; (8) Psoriatic arthritis; (9) Degenerative joint disease of hips.

The 350 cases of arthritis were divided as illustrated in table 1, which gives the number of cases in each category.

(B) Materials:

The following prednisolone preparations were employed in this study:

1. Prenisolone (0.5 mg.) plus Aspirin, Buffered* Delta-1 Hydrocortisone) .5 mg. II Beta, 17 Alpha, 21 Tri Hydiozl 1-4 Pregnadien 3-20 dione). Acetysalicylic Acid 300 mg. Calcium Carbonate 200 mg.
2. Prednisolone (2.5 mg.) Buffered*— Cal. Carbonate 250 mg.-Magnesium Carbonate 40 mg.—Magnesium Oxide 20 mg.
3. Prednisolone (5.0 mg.) Buffered*— Calcium Carbonate 250 mg., Magnesium Oxide 20 mg.—Magnesium Carbonate 40 mg.

One hundred and fifty cases (table 1) were maintained on prednisolone (0.5) plus aspirin plus calcium carbonate buffered tablets with an average dose of 2 tablets three times per day. These cases have been followed for a period of one year.

TABLE 1.—TYPES OF ARTHRITIS TREATED AND PREPARATIONS EMPLOYED

Type Treated	No. of Cases on Prednisolone (0.5 mg.) Plus Aspirin* (Buffered)	No. of Cases on Prednisolone (2.5 mg.) (Buffered)*	No. of Cases on Prednisolone (5 mg.) (Buffered)*
Rheumatoid	40	20	50
Osteoarthritis	30	20	40
Traumatic	20	10	5
Algias	20	5	10
Gout	5	0	10
Degenerative Hips	10	0	0
Collagen Disease			
A) Lupes	0	0	2
B) Scleroderma	0	0	3
Psoriatic Arthritis	5	0	5
Bursitis	20	10	10
Totals	150	65	135

One hundred and thirty-five cases were maintained on 5.0 mg. prednisolone tablets with an average dose of one tablet three times per day,

*All three of these preparations were kindly supplied by The Upjohn Company, Kalamazoo, Michigan. These preparations are obtainable under the trade names of: (1) Cordex® Buffered; (2) Delta-Cortef® (2.5 mg.); and (3) Delta-Cortef® (5.0 mg.).

Submitted April 25, 1957.

The Authors

- Dr. Szucs, Youngstown, is a member of the senior medical, and senior cardiology staffs and in charge of Peripheral Vascular and Arthritis Clinic at St. Elizabeth Hospital; consultant in cardiology and arthritis, Woodside Receiving Hospital.
- Dr. Petraglia, Youngstown, is first year medical resident, St. Elizabeth Hospital.
- Dr. Galose, Youngstown, is intern at St. Elizabeth Hospital.

and several cases had to be carried on 4 tablets daily for one week or more with a subsequent return to 3 tablets daily. These cases have been followed for six months or longer.

Sixty-five cases were maintained on 2.5 mg. prednisolone tablets for a period of six months. It was not tried in all forms of arthritis because of the limited supply of the drug at the time of this study.

(C) Methods:

All groups studied in this series had the following clinical and laboratory diagnostic study:

1. Complete physical examination with differential diagnosis.

2. Laboratory aids included complete blood count, LE test, sedimentation rate, "C" reactive protein, antistreptolysin O titer, uric acid levels, 24 hour creatinine excretion, latex flocculation test, roentgenograms as needed, nonprotein nitrogen, blood sugar and electrocardiograms as needed. Antihyaluronidase and streptokinase tests were also done as further aids in differential diagnosis.

The differentiation and classification of each case was recorded before specific medication was started and a series of controls were run in each group.

Individuals in the control group were given a placebo of sugar tablets.

The evaluation of the results of the therapeutic regime used in each case was based upon physical findings such as reduced swelling, reduced stiffness and increased action (motion). These findings were correlated with the laboratory studies such as improved blood picture, sedimentation rate, uric acid levels, etc.

Each case was further carefully followed for symptoms of gastritis, dermatitis, Cushing syndrome and hyperglycemia.

RESULTS

The results obtained with these preparations in the various types of arthritis are summarized in table 2. For the sake of brevity we have also included in table 2 all observations pertaining to physiologic side effects of these drugs.

TABLE 2.—TYPES OF ARTHRITIS TREATED, DEGREE OF IMPROVEMENT AND SIDE REACTIONS

Degree of Improvement and Side Reactions	Prednisolone (0.5 mg.) Plus Aspirin 150 Cases	Prednisolone (2.5 mg.) Buffered 65 Cases	Prednisolone 5 mg. Buffered 135 Cases
Reduced Swelling	xxx	xxx	xxx
Reduced Stiffness	xxx	xxx	xxxx
Increased Action (Motion)	xxx	xxx	xxxx
Improved Blood Picture	xxx	xxx	xxxx
Hyperglycemia	0	0	0
Gastritis	0	0	xx
Dermatitis	0	0	0
Cushing's Syndrome	0	0	x

*Grading of Results:

0=None
x=Slight Reaction or Improvement
xx=Average Reaction or Improvement
xxx=Moderate Reaction or Improvement
xxxx=Intensive Reaction or Improvement

EVALUATION OF RESULTS

In the 150 clinical cases maintained on the 0.5 mg. prenisolone-aspirin tablets at the dosage previously enumerated and for a period of one year, we observed no cases of gastritis, dermatitis, hyperglycemia or edema with the use of this drug. The best results of reduced swelling and stiffness and of increased motion were found in osteoarthritis cases of the extremities, algias, traumatic arthritis and arthritis of gout. Next best results were obtained in degenerative joint disease cases. Only fair results were obtained in rheumatoid arthritis, miscellaneous bursitis, the collagen diseases and in psoriatic arthritis. On the whole the medication caused no ill effects in any of the cases studied, but we observed more satisfactory results in some forms of arthritis than in others.

The six month study in 65 cases of arthritis with 2.5 mg. prednisolone buffered tablets revealed this therapy to be well tolerated with no side effects resulting such as those enumerated in table 2. There were a limited number of cases on this preparation due to a lack of the drug at the time of this work.

For a period of six months or longer, 135 cases were observed and studied on a 5.0 mg. prednisolone level as mentioned in the foregoing. In a number of cases, complaints of gastritis were obtained. In two cases, a borderline Cushing's snydrome was observed. There were no symptoms of dermatitis or urticaria observed. The results with this treatment were gratifying but careful observation was needed in a number of cases. The reduction of swelling and stiffness and the increased motion were considered excellent in the most severe types of arthritis. Most of the gastric symptoms disappeared with additional anti-acid therapy. We have found this mode of treatment to have its most beneficial results in the more severe types of cases and is preferable to either of the other methods of treatment. It is necessary to revert back to the milder forms of therapy once the severer symptoms of rheumatoid arthritis are controlled.

CONCLUSION AND SUMMARY

If we accept the usefulness of these drugs we must also be cognizant of the fact that their use is a matter of individual clinical judgment on the part of the clinician. This individual appraisal is a necessary consequence arising from the pharmacologic nature and effects of these steroids. In every instance where a clinician contemplates employing sizable doses for more than a brief period of time, he must anticipate side effects of greater or lesser magnitude and seriousness. These side effects are pharmacologic disturbances resulting in the altered metabolism, of appearance and of the

psyche. They occur in a varying proportion of cases without much regard to the underlying disease and larger doses give rise to greater side effects. These side effects usually regress when the drug is withdrawn.

This clinical study was carried out in three states. Our evaluation was based on both objective symptomatology and laboratory studies. The results in the three forms of therapy were gratifying and each has a specific place in arthritis therapy. In the milder forms or for a long period of therapy, 0.5 mg. prednisolone plus aspirin buffered tablets is the drug of choice.

In the little more severe types of arthralgias, a level of 2.5 mg. of prednisolone is advocated as no side effects were found on objective observation or on laboratory studies. Prednisolone at levels of 5.0 mg. was found to be very beneficial in severe forms of arthritis and in acute flare-ups of severe cases. As the arthritis came under control we found a gradual change to one of the milder forms of therapy necessary to minimize side effects, which were prone to occur if the patient was continued on the 5.0 milligrams of prednisolone.

Acknowledgment: We wish to thank the following physicians for their cooperation: Drs. Stanley Hallinbeck, F. Ross, E. End, S. Bernhardt, all of Milwaukee, Wisconsin, and Marquette University.

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Ornithosis—Psittacosis Cases Transmitted from Turkeys

An outbreak of ornithosis among 250 employees of a Wisconsin turkey-processing plant occurred during the interval between August 15, 1956, and December 28, 1956. Ten manifest cases, serologically confirmed, were observed during that period. It is likely that some cases escaped detection, and there is evidence that an indeterminate number of clinically inapparent infections occurred.

There is substantial evidence . . . that the disease was transmitted from infected turkeys to man in the process of handling and by aerosol transmission.

The possibility of a psittacotic source of infection should always be considered in cases exhibiting the syndrome of atypical pneumonia. Blood specimens taken in the acute and convalescent stages should be tested for complement fixation antibodies. This often requires follow-up procedures after the patient has made an apparent recovery.—Rex E. Graber, M. D., M. P. H., Chippewa Falls: *Wisconsin M. J.*, 56:341, August, 1957.

Hazards of Steroid Treatment in Asthmatic Bronchitis Cases

In asthmatic bronchitis cases we are going to be confronted with the situation where the patient is in distress, has symptoms of cough and wheezing, often sitting up at night to get his breath, and requiring a doctor's visit. This many times builds up a great fear in the patient that perhaps he cannot reach the doctor in time to get help, so we have a large psychogenic factor in a great many of these cases of asthmatic bronchitis.

Then the patient hears of some friend who has had some of the steroids, and is getting along fine and having no trouble at all. "Why can't I have that instead of fiddling along with this suppository and this shot?" he asks. In the first place, you have to sit down and have a talk with these people and outline their status as far as the future, long-term care of the condition is concerned.

Usually at the same time you talk to them about the hazards of the steroids. I am very frank with these people and perhaps at times overemphasize the statistics in order to make them fully aware that they can't take steroids like aspirins or the antihistamines; they are more of a last resort type of treatment rather than the first type to use. After that is understood and we have checked on any skin tests that might be indicated for specific factors, then we start talking about eliminating respiratory irritants in general.

In a lot of these cases where skin tests are unhandy to do, you can get by perfectly well without them, particularly in older people. You may have some pretty good ideas as to whether dusts, temperature changes, dampness, drafts, or anything similar are particularly bothering him. You can get some idea as to whether a pet is causing the trouble.

In general, whether the skin test is negative or positive in this group of people, I tell them they ought to have a bedroom as lint-free and dust-free as possible; to sleep in a warm bedroom that is draft-free, and to get rid of the feather pillow, not particularly because they are feather-sensitive but because the pillows are another source of dust and mold. It is good to have the bedroom floor bare or with linoleum or linoleum tile, or washable rugs. Get rid of venetian blinds and drapes, and have no pets with hair or feathers in the house. This means that dogs, cats, parrots, parakeets, and such should be eliminated.

The steroids are the last thing; I say the last because that is where I think they belong. If we have a patient with asthma severe enough to warrant hospitalization despite having followed a good conservative program, then I think that it's time to treat him with the steroids.—Lowell Henderson, M. D., Rochester, Minn.: *Minnesota Med.*, 40:481, July, 1957.

Upper Respiratory Infections, Antimicrobial Agents And Acute Rheumatic Fever

DAVID H. GREEGOR, M. D.

The Author

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HISTORICAL

GROUP A streptococcus is the offending agent in many upper respiratory infections—we accept the proof that this same streptococcus is the criminal whose infections precipitate acute rheumatic fever—and consequently we realize that one of our main methods of preventing rheumatic fever attacks is the prompt recognition of streptococcal infections followed by effective therapy which not only clears the disease symptoms but completely eradicates the streptococci from the patient.

The most conclusive proof of this was reported by Wannamaker[1] who studied 2,340 cases of exudative tonsillitis (in military personnel) admitted to the hospital of the Francis E. Warren Air Force Base during the period January 1949 to February 1950. Eleven hundred and seventy-eight were treated with injected penicillin while 1,162 untreated, served as controls. During the first part of the study an actual epidemic of hemolytic streptococcus was in progress and it is noteworthy to see that 22 of the untreated controls subsequently developed acute rheumatic fever in comparison to only 3 of the treated group. At the end of the study the treated group showed only 7 cases, to 35 cases of the untreated. Throat cultures had previously demonstrated that most of the cases harbored hemolytic streptococcus.

The Wannamaker group treated 80 additional cases with Aureomycin® and had no cases of rheumatic fever develop but were unable to completely eradicate the streptococci from these patients with this agent.

EFFECT OF SULFONAMIDES AND BICILLIN

Since the sulfonamides have already been proved nonbactericidal against the streptococci[2] the Wannamaker report perhaps simplifies our approach to the full blown case of exudative tonsillitis. Breese[3] threw additional support behind this attack with a report in 1953 on 792 children (ages 2 to 18) with proven cases of hemolytic streptococcus infection. Some were treated with sulfonamides, others with Aureomycin, many with injectable procaine penicillin G and the majority with injectable Bicillin® (N,N'-dibenzylethylenediamine dipenicillin G). Of the 1,204 streptococcal infections occurring in these 792 children only one case of acute rheumatic fever developed. This most certainly is an enviable report when one considers previous figures of 3 per cent rheumatic fever rate development in untreated streptococcal infections.

Submitted June 13, 1957.

From these reports it would seem that the problem of preventing rheumatic fever complications to upper respiratory disease is not an overly difficult one. One must administer 300,000 to 600,000 units of procaine penicillin every 3 days for three injections (or one injection of 600,000 to 1,200,000 units of Bicillin) to each case caused by streptococcus (as recommended at the present time by the American Heart Association). However the practitioner is immediately confronted with these difficulties:

(1) It is not always possible to determine clinically which upper respiratory infections are streptococcal and throat cultures may be expensive, time consuming—and for all practical purposes, impossible.

(2) Reports of serious (even fatal) penicillin anaphylactic reactions are growing in number and a recent editorial in *The Journal of the American Medical Association* hints that the unreported cases greatly outnumber those listed in our journals. This should not prevent our employing this valuable agent but it does make one require very specific reasons for its use. One bright star in this field reassures us that children—the chief objects of our efforts in rheumatic fever prevention—have not been overly victimized by serious penicillin reactions.

(3) No matter how afraid we doctors are of rheumatic fever, the patients (especially the small ones) are not always sufficiently impressed to permit one to three injections each time they have an upper respiratory infection of unknown or suspicious etiology.

I

RESULTS OF TREATMENT

We have attempted to determine how effective prompt treatment with various antimicrobial schedules is in rheumatic fever prevention. To this end we studied our own records of unselected cases of upper respiratory tract infection. Our series totals 657 cases. The etiologic agent was proven by culture in only a very small number of cases. The study covers the years 1947

through the first part of 1957. During at least two separate years of this study there was a high incidence of streptococcal infections reported in the general public.

Table 1 portrays the breakdown by age groups and disease entity.

TABLE 1.—CLASSIFICATION BY AGE GROUPS AND DISEASE ENTITY

Diagnosis	Under 18 yrs. of age.	Over 18	Total
Acute Tonsillitis	170	94	264
Acute Pharyngitis	43	100	143
Acute Otitis Media	62	16	78
Acute Bronchitis or Combinations of Bronchitis, Laryngitis, Etc.	82	90	172
Total	**357**	**300**	**657**

Table 2 reports the varied treatment programs and the number of cases involved in each program.

TABLE 2.—TREATMENT PROGRAMS

	Tonsillitis	Pharyngitis	Otitis Media	Combinations
1 injection 400,000 U. procaine penicillin	120	59	44	52
2 injections, on consecutive days of 400,000 U. penicillin each	54	24	10	5
More than 2 injections of penicillin	7	7	2	10
400,000 U. injected penicillin followed by 3 days of erythromycin	8	0	1	0
2 injections of penicillin followed by erythromycin	3	0	0	0
400,000 U. penicillin followed by oral phenoxymethyl penicillin	15	0	0	0
Erythromycin	12	9	0	7
Tetracycline	30	32	21	90
Sulfonamides	14	10	0	7
Oral phenoxymethyl penicillin	1	2	0	1
Symptomatic treatment only				154
Total	**264**	**143**	**78**	**326**

Table 3 classifies the results of treatments:

TABLE 3.—RESULTS OF TREATMENT

Total cases treated	657
Recurrence of symptoms within 10 days	3
Acute rheumatic fever developed	0
Acute glomerulo-nephritis developed	2

Both cases of nephritis—one aged 4 and the other 32—followed acute exudative tonsillitis treated with one injection of 400,000 U. procaine penicillin followed by 3 days of erythromycin.

Two cases of rheumatic fever were encountered during the period of this study, neither of which had any history of preceding infection.

Two additional cases of nephritis were treated during this case study—one came to us with the history of an antecedent acute otitis media (treatment not known to us) and the other with no history of preceding infection.

II

The second series of cases, table 4, consists of an analysis of 21 consecutive unselected admissions of acute rheumatic fever to the Columbus Children's Hospital during 1956. All except one were in their first attack.

This Case Study demonstrates a number of important features:

(1) Over 75 per cent of the cases received *no* treatment of the antecedent illness.

(2) Only 35 per cent had recognizable preceding infection of the throat.

(3) Twenty-five per cent had no recognizable antecedent illness.

SUMMARY AND CONCLUSIONS

1. Effective and prompt treatment of upper respiratory infections, especially those of streptococcal origin, definitely cuts the incidence of rheumatic fever follow-ups.

2. Treatment of choice for any streptococcal infection is that recommended by the American Heart Association i. e. 300,000 units procaine penicillin injected every third day for three injections or one injection of 600,000 to 1,200,000 units Bicillin.

3. Treatment should be prompt. Wannamaker felt that some of his recurrences of tonsillitis and acute rheumatic fever were due to the delay between onset of symptoms and presentation of the soldier for treatment. Perhaps one of the main reasons for the absence of rheumatic fever in our series of upper respiratory infections, even though many were not treated with penicillin, was the fact that the vast majority presented

TABLE 4.—ANALYSIS OF 21 CONSECUTIVE CASES OF ACUTE RHEUMATIC FEVER ADMITTED TO CHILDREN'S HOSPITAL, COLUMBUS, 1956

Antecedent Illness (by history)	Reported treatment of antecedent illness				
	No therapy	1 injection of penicillin	1 injection of penicillin plus penicillin tablets	Sulfonamides	Rx not determined
Acute tonsillitis	2	–	1	1	–
"Sore throat"	5	1	–	2	–
No previous illness recognized	5	–	–	–	–
"Cold and cough"	1	–	–	–	–
Over 8 months weakness, lassitude and low grade fever	2	–	–	–	–
Fever—no localizing symptoms	–	–	–	–	1
Total	**15**	**1**	**1**	**3**	**1**

themselves for treatment in less than 24 hours after onset of symptoms.

4. The diagnosis of the classical case of acute streptococcal pharyngitis may be assumed anytime the patient presents a marked exudative tonsillitis or the combination of sudden onset of sore throat, marked constitutional reaction, fever, enlarged tender cervical nodes, with infection, edema or exudate of the pharynx.

Our second series of cases demonstrates how difficult it is to always recognize the types of illnesses in children which precipitate rheumatic fever. Almost half (46 per cent) of the cases had no antecedent illness that the parents could remember as involving either the ears or throat and 26 per cent recognized no preceding illness. Until better office and bedside methods are devised for recognizing streptococcal, "pre-rheumatic" illness the physician treating the feverish child will have to lean over backwards to make sure that his therapy is effective.

5. Since there are some disadvantages to the frequent and repeated use of penicillin injections it might be well to study the efficacy of a program of one or two daily injections of penicillin and, if symptoms promptly cleared, following up with phenoxymethyl penicillin orally for three or four days. In the case of adults where penicillin reactions occur more frequently and may even occur outside of the physician's office if the patient is taking oral penicillin it might be an advantage to use erythromycin for the three or four day follow-up. Haight[4] and others have already demonstrated the effectiveness of erythromycin against the streptococci and this antibiotic's record of no serious reactions is truly an enviable one.

These programs have not been used on large enough groups to be recommended as yet but they are suggested as a basis for further statistical and bacteriological study.

6. When we realize that the five treatment "failures'' in our upper respiratory infections series (two nephritis and three recurrences of symptoms) were all in cases of marked tonsillitis treated by one injection of 400,000 U. fortified procaine penicillin followed with either oral phenoxymethyl penicillin or erythromycin we must conclude that the tonsillitis cases certainly deserve at least the three penicillin injections recommended by the American Heart Association.

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The Properties and Uses of Histamine Diphosphate

It is desirable to have an understanding of the properties and uses of histamine diphosphate to better appreciate its use. According to Horton, histamine dilates the arterioles, venules, and capillaries, causes a greater increase in blood flow to the central nervous system than any other known drug, produces dilatation of the coronary arteries, causes an increase in oxygen consumption, increases gastric acidity, and seems to produce cortical discharge of steroids in man more promptly than any other drug. Histamine causes an increased sense of well-being with a tendency toward euphoria, an increase in appetite, a feeling of warmth, especially in the extremities, and increase in muscular strength.

Histamine has been used for many diseases. Horton has used histamine diphosphate in the treatment of multiple sclerosis, Ménière's disease and associated deafness, histamine encephalgia, retrobulbar neuritis, and many other eye diseases. Kestler reported on the administration of histamine in rheumatoid arthritis, hypertrophic arthritis, and osteoarthritis of the knee with the highest incidence of success seen in hypertrophic arthritis and osteoarthritis. Butler and Thomas treated 34 patients with migraine with histamine; 7 were improved and 24 became symptom-free. Macy and Horton used histamine intravenously in migraine. Although it was effective in 33 to 50 per cent of cases of typical migraine and in 40 to 65 per cent of atypical cases, they had better results with histamine by the subcutaneous route.

Schizophrenic, involutional psychotic, and manic-depressive patients were treated with histamine by Sackler *et al.;* they treated 38 patients. In general, the results seemed to be as good as those from electroshock therapy, and the treatment was less unpleasant for the patient. Sanford, Butler, and Kennedy treated a series of hemophiliacs with histamine. Five active cycles of bleeding responded with cessation of bleeding after the first or second injection.—A. O. Hendrickson, M. D., and W. O. Hendrickson, M. D., Wausau, Wis.: *Wisconsin M. J.*, 56:357, September, 1957.

Carcinoma of the Male Breast

Carcinoma of the male breast is reported to occur approximately once in every 100 breast cancers. Statistics vary from .87 per cent to 2.2 per cent with respect to all breast cancer. Sachs stated that only .38 per cent of male carcinomas are of the breast. Neal found 30.36 per cent of 165 male breast tumors to be carcinoma and 6 per cent to be sarcoma. The incidence of bilateral malignancy was 2.7 per cent, or approximately the same as in females. This low incidence may be related to the lack of the cyclic stimulus present in the female.—F. A. Selecman, M. D., et al., Dallas: *Texas State J. Med.*, 53:694, September, 1957.

Agranulocytosis Due To Chlorpromazine

MORTON ROSENTHAL, M.D., and ANGELINE E. O'DONNELL, M.D.

THE treatment spectrum for mental disease has been considerably broadened in the past several years with the introduction of a variety of chemotherapeutic agents, whereas previously, electro-convulsive therapy and insulin coma were the primary physical therapies available. Of this group of therapeutic agents now referred to as the tranquilizers or ataraxic drugs, our experience has been the most extensive with chlorpromazine. Chlorpromazine hydrochloride is represented chemically as —2-Chloro-10-(3-dimethylaminopropyl) phenothiazine hydrochloride. This drug principally produces depression of the central nervous system. Its other actions include antispasmodic, antihistaminic, hypotensive, hypothermic, adrenalytic and anti-emetic effects.

This report, however, is concerned primarily with the toxic effects of this drug on the bone marrow in depression of the granulocyte series. We believe that it is of interest because it represents an experience with a very large unselected group of patients treated over approximately a two year period.

Our use of this drug began in March, 1955, and it is estimated that 1,440 patients have been since treated with chlorpromazine. Initially, 50 patients were treated at any one time, either alone or in combination with other agents. Gradually the number of patients receiving this drug has increased so that presently about 50 per cent of the hospital census or about 175 persons at any one time are receiving chlorpromazine therapy. The dosage schedules have been variable and have ranged from 100 to 2,000 mg. daily with the usual daily dosage from 400 to 800 mg. All patients receiving chlorpromazine have had weekly white blood cell counts.

COMPLICATIONS IN THERAPY

A survey discloses the following problems encountered in therapy with chlorpromazine: hypotension, obstructive jaundice, dermatitis, photosensitivity of the skin, angioneurotic edema, Parkinson-like state, endocrine changes, including lactation and disturbed menstrual cycle, raising of the pain threshold and granulocyte depression. The latter has proven to be the most serious complication to date. A review of cases reported shows 45 instances of agranulocytosis, with 17 fatalities. Subsequent reports indicate at least three other deaths associated with chlorpromazine administration.[2,3]

We have seen four patients with agranulocytosis due to chlorpromazine, with two deaths resulting. The age range of these patients was 49 to 64 years. Three of the patients were females, a circumstance which seems to agree with the experiences reported by others.[4,5] The average duration of therapy before any blood changes were detected was 40 days with a range of 26 to 49 days. The maximum dosage of the drug received by three of the patients was 800 mg. daily while the fourth received 600 mg. daily. Of particular interest to the authors in analyzing this series is the fact that two of the patients developed a fine papular eruption of the extremities seven and ten days respectively before agranulocytosis occurred, and that in one case, (that of a patient who subsequently expired) an episode of hypotension occurred 11 days after chlorpromazine was started. The following case report is presented:

Submitted June 19, 1957.

The Authors

● Dr. Rosenthal, Cleveland, is a member of the medical staff, Mt. Sinai Hospital; consultant in medicine, Cleveland Receiving Hospital; Demonstrator in Medicine, Western Reserve University School of Medicine.

● Dr. O'Donnell, Cleveland, is staff psychiatrist, Cleveland Receiving Hospital.

CASE REPORT

Mrs.___, a 58 year old, white female was admitted to the Cleveland Receiving Hospital as a Court Placement on March 25, 1955. The history of mental disease was of some 20 years' duration with gradual personality changes becoming apparent to the family. She became very suspicious, argumentative and asocial. There was the frequent complaint of headache and vomiting spells, and the patient would accuse a fictitious person at first, and then her husband, of dropping poison on the floor. The home situation became so bad that her husband secured a divorce and the three children left the home when they were old enough to care for their own needs. The present hospitalization became necessary when the patient grew increasingly hostile to her neighbors, became very noisy and then locked herself up in her room.

On admission to the hospital, the patient was described as hostile, suspicious and somewhat depressed. Her speech was rambling, her judgment was grossly impaired and her insight was negligible. Past medical history included a hysterectomy done some years before and jaundice, etiology unknown, in 1948. Physical examination was negative except for grade I mitral systolic murmur, divergent strabismus of the right eye and a lower median vertical healed surgical scar. Admission laboratory work including urinalysis,

hemoglobin, red and white blood cell counts, blood serology, blood urea nitrogen and electrocardiogram was within normal limits.

During the period of hospitalization, the patient was observed to be restless, hostile, noisy and hallucinated. She was very demanding and argumentative. Chlorpromazine was started on May 16, 1955, with a dosage of 200 mg. twice daily. Ten cc. of paraldehyde was given at bedtime on three occasions. On May 27th the dosage of chlorpromazine was increased to 600 mg. daily. On May 27 an epsiode of syncope occurred and the blood pressure was observed to be depressed, the lowest recorded level being 84/54. Ephedrine sulfate, 50 mg., was given intravenously and gradual improvement was noted.

On June 25, 1955, the patient complained of pruritus and swelling of both arms. This was three days after she had been outdoors and had developed some sunburn. There was a fine papular eruption on the extensor surfaces of both forearms and on the hands. Patient received Clistin,® 4 mg. twice daily for three days, and then Pyribenzamine,® 50 mg. twice daily.

On July 3, 1955, the patient complained of a choking spell, followed by a sore throat. The temperature was 39.4°C., and examination revealed infection of the pharynx with many ulcerated areas present. An emergency blood count revealed the hemoglobin to be 8.4 grams, red blood cell count 3.21 million, and white blood cell count 1,800. The differential revealed absence of all granulocytes. The patient was immediately transferred to the medical ward of Cleveland City Hospital. Here the initial physical examination was as reported in the foregoing with the following also noted: A grade II rough aortic systolic murmur and moderate pitting edema of both feet, more marked on the left.

By the following day, the ulcerative stomatitis and pharyngitis were more marked, with a drop in temperature to 37.8°C. Procaine penicillin, started on July 3rd, was continued in a dosage of 300,000 units twice daily, and Achromycin,® 250 mg. four times a day, was started. The peripheral blood showed red blood cells 3.93 million, hemoglobin 9.9 grams (63 per cent), hematocrit 32.2, white blood cell count 900, with a differential showing absence of all granulocytes.

Daily white blood cell counts ranged from 600 to 1200 with no granulocytes present. Blood chemistries on July 5 and July 6 showed blood urea nitrogen 11.2 mg. per 100 ml., fasting blood sugar 68 mg./100 ml., CO_2 combining power 60 volumes per cent, icterus index 7, cholesterol 224 mg./100 ml. with cholesterol esters 132, phosphorus 4 mg./100 ml., alkaline phosphatase 5.9 Bodansky units, chlorides 97, sodium 140 and potassium 3.4 mEq. per liter, total proteins 6.6 grams per 100 ml. with albumin 4.2 and globulin 2.4 G/100 ml., prothrombin time 100 per cent, cephalin flocculation negative. A bone marrow aspiration from the sternum on July 5, and repeated on July 7 from the iliac crest, was interpreted on both occasions as indicative of an aplastic marrow.

The patient's hospital course was stormy. The temperature that initially dropped, gradually rose reaching a peak of 40°C. The patient complained of severe mouth and throat pain. She was given intravenous fluids and 2 per cent Pontocaine® was sprayed on the oral ulcerations. On July 11, 1955, cortisone, 50 mg. every six hours was started. By July 16 the condition of the patient had deteriorated considerably. She was very lethargic and unresponsive. Examination showed bilateral basilar rales and bilateral Babinski reflexes to be present. A lumbar puncture on this date was negative. A culture of the mouth lesions showed a moderate growth of *Aerobacter aerogenes* and *Candida tropicalis*.

On July 17 with the patient unconscious, cortisone was given intramuscularly, aqueous penicillin was substituted and she received 250,000 units every four hours, as well as streptomycin 1 gram every 12 hours. A shock-like state developed and in order to correct this, Levophed® was given with the intravenous fluids. This maintained the blood pressure in a range of 100 to 110 mm. systolic. The temperature was 39°C and pulse 140 per minute. There was slight resistance to flexion of the neck; coarse rales were heard throughout the chest; the abdomen was distended and tympanitic with diminished bowel sounds. Petechiae were present on the anterior abdominal wall. Blood cultures were obtained at this time.

The patient failed to respond and she expired on July 17, 1955.

CONCLUSIONS

It is apparent that the use of chlorpromazine is attended by certain definite hazards and particularly so in institutions where the treatment program includes large dosage schedules over long periods of time. While agranulocytosis due to chlorpromazine is infrequent, its seriousness should be fully appreciated by all physicians using this drug. In spite of frequent blood cell counts in an effort to detect early changes and daily supervision by professional personnel alerted to this problem, we have been unable to eliminate this complication.

A summary is reported of our experience over a two year period in which 1,440 patients have been treated with chlorpromazine. There were four cases of agranulocytosis with two deaths resulting.

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Incidence of Penicillin Reactions Shows Marked Increase

Penicillin reactions can be serious, and frequently are fatal. The incidence is markedly increasing as more patients are being sensitized to the drug.

There is no safe way of giving penicillin to an anaphylactically sensitized patient.

Symptoms of anaphylaxis are immediate and severe, when they occur.

All precautions should be used to avoid reactions. Patients suspected of being sensitized should not be given penicillin.

It is imperative to have proper medications available for the control of serious reactions when penicillin is being used.—Joel D. Teigland, M. D., Des Moines: *J. Iowa M. Soc.*, 47:514, Aug., 1957.

A Comparative Study of Two New Non-Narcotic Antitussive Drugs

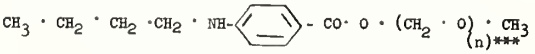
S. WILLIAM SIMON, M. D.

THE prescribing physician has long felt the need for an effective drug which would inhibit cough without also having the well known disadvantages of narcotics: possible addiction, toxicity, depressing action on respiration, sedation and usually constipation. If also there was an added expectorant effect, this would enhance its value.

The cough reflex is acted upon by antitussive agents at two points, centrally in the medulla oblongata and peripherally in the afferent and efferent branches of the reflex arc. Cough may be relieved peripherally by local anesthesia but this is not possible where the receptors of cough stimuli cannot be reached.[2] The narcotics inhibit cough by central action.

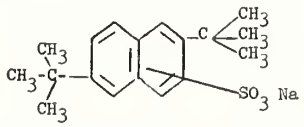
THE DRUGS

Tessalon®* is an esterfied polymericglycol, alkaloid free, antitussive agent with the following chemical formula: methoxypoly (ethyleneoxy)-ethyl-p butylaminobenzoate and has the following structural formula:



This analogue of local anesthetic drugs acts by anesthetizing the dilation receptors of the lungs, thereby preventing the forcible inspiration which precedes the cough and either causes marked diminution or complete arrest thereof.[1,2,7] Clinical reports from Europe and our own have borne this out.[5,8,9,10]

L.1633 known as Becantyl in the United Kingdom and as Becantex on the European Continent is Sodium 2.6 ditertiarybutylnaphtalene monosulphonate. It has the following structural formula:



The action of this drug is also peripheral, probably in the afferent branch of the reflex arc, blocking cough due to irritation of the bronchial tract.[3] European clinicians have been impressed with its antitussive properties.[4,6]

There were no reports of sedation, habituation, euphoria, inhibition of the respiratory center or other toxic effects from either drug when given in therapeutic doses.

Submitted February 25, 1957.

*Supplied through the courtesy of CIBA Pharmaceutical Products Inc., Summit, New Jersey.

***n=principle component is 9 with adjacent homologues.

The Author

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THE PATIENTS

Fifty-nine unselected patients all carrying diagnoses of pulmonary emphysema with chronic asthmatic bronchitis and who had been under stabilized treatment in the Allergy Clinic for at least one year, received the antitussive drugs. These men ranged in age from 35 to 76 years, the average being 58 years. The mean duration of chronic lung disease was eighteen and a half years. All had chronic cough productive of one-quarter to one cup of thick, gray sputum every 24 hours. The productive cough relieved totally or in part the shortness of breath and wheezing in all. No seasonal or geographical influence was noted, but symptoms were aggravated by damp weather or acute respiratory infections. The cough and wheezing while annoying during the night, were much worse on first arising in the morning. There were no instances of definite allergy. All had received iodides, xanthines and various bronchodilator drugs as well as injections of stock vaccines. Cough mixtures containing Hycodan® were routinely prescribed.

METHOD

A printed form was used for each patient and on every visit (approximately weekly) he was asked routine questions relative to the efficacy of his medication in controlling cough, thinning and amount of sputum, etc. This questioning and tabulation was done by a disinterested patient, a member of the group, who could talk to the others on their own level although he is a college graduate. It was noted, at times, that the patient's responses were not the same to his physician and tabulator. In all cases, the latter answers were accepted without further question.

Tessalon in one or two 50 mg. capsules and Becantex in 30 mg. coated tablets were taken three times daily or four times a day with additional doses added, if necessary. At first, cough mixtures were continued but without narcotics. Later, the new drugs were tried without any other

cough remedies. Blood counts and urinalyses were performed before, during and after antitussive therapy.

RESULTS

This study covers the treatment of 59 patients for a total of 4,724 patient days. Eighteen patients received only Tessalon, seven only Becantex and 34 received both drugs. In those receiving but one drug, no comparison could be made but the response is included in the series for that drug. The minimum period of treatment was eight days and the maximum 115 days. The mean average per patient was approximately 80 days.

In classifying response to treatment the word "Excellent" signified 75 to 100 per cent relief of cough, "Good" 50 to 75 per cent relief, "Fair" 25 to 50 per cent relief and "None" 0 to 25 per cent relief. These results are largely subjective but they were many times corroborated by the patients' roommates.

Smaller and larger doses of the drugs were tried but in most cases less medication than noted was ineffective. Increased dosage over the amounts stated gave no better relief nor did it produce evidence of toxicity. Dosage, in every case, was individualized for the patient; the medication being taken regularly but also at the time the most severe paroxysms of cough were expected. Each drug was used a minimum of two weeks by each patient and in most cases they were alternated at least three times. No significant changes in blood count or urinalysis were noted.

Table 1 illustrates the effect of the two drugs on cough, table 2 on the amount of sputum and table 3 on the consistency of sputum. The patients' preference in relief of all bronchial symptoms is shown in table 4.

TABLE 1.—RELIEF OF COUGH BY ANTITUSSIVE DRUGS

Relief	Tessalon Patients	%	Becantex Patients	%
Excellent	29	56	10	24
Good	14	27	12	29
Fair	6	11	11	27
None	3	6	8	20
Totals	52	100	41	100

TABLE 2.—INFLUENCE OF ANTITUSSIVE DRUGS ON AMOUNT OF SPUTUM

Amt. of Sputum	Tessalon Patients	%	Becantex Patients	%
Less	33	63	8	19
More	3*	6	2	5
Same	16	31	31	76
Totals	52	100	41	100

*Note—Two of these patients noted more but lighter sputum.

TABLE 3.—INFLUENCE OF ANTITUSSIVE DRUGS ON CONSISTENCY OF SPUTUM

Consistency of Sputum	Tessalon Patients	%	Becantex Patients	%
Lighter	31	60	7	17
Heavier	1	2	21	51
Same	20	38	13	32
Totals	52	100	41	100

TABLE 4.—PATIENTS' DRUG PREFERENCE

Preferred Tessalon	20	(59%)
Preferred Becantex	4	(12%)
No difference	10	(29%)
Total	34	

DISCUSSION

In this small series of patients, Tessalon was judged excellent or good as an antitussive in 83 per cent of those using it, while 53 per cent obtained this result with Becantex. Sputum was lighter in consistency and less in amount with the Tessalon while with Becantex it was more often thicker and unchanged in amount. Patient preference agreed with these findings.

Unfortunately, the results obtained for chronic bronchial infection did not apply when an acute infection was superimposed. Whether this was due to the acute inflammation and swelling or to added upper respiratory infection or postnasal drip is unknown.

Asthma was unaffected by the drugs but shortness of breath was decreased in those patients experiencing lessened, thinner sputum.

SUMMARY AND CONCLUSIONS

Two new non-narcotic antitussive drugs were given interchangeably to patients suffering from chronic asthmatic bronchitis and pulmonary emphysema. In this small series, Tessalon apparently was superior to Becantex in stopping cough and lessening the amount of a thinner sputum. These new drugs replaced formerly used narcotics efficiently without undesirable side effects.

Acknowledgement: The author wishes to express his appreciation for the assistance of Freeland G. White, B. A., in the preparation of this paper.

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Arteriovenous Aneurysm of the Ovarian Artery and Vein

(A Case Report)

LEONARD GOTTESMAN, M.D., LAWRENCE J. WILCHINS, M.D.,
and NATHAN ARONOFF, M.D.

IN reviewing the literature over the past 15 years, numerous instances of arteriovenous aneurysms are found. However, only a few instances of such aneurysms are reported involving the pelvic organs.[1, 2, 3, 4] The case herein reported is the first following salpingo-oophorectomy for a tubal pregnancy and precipitated nine years later by a normal delivery.

CASE REPORT

Mrs. ..... was first admitted to the Jewish Hospital, Cincinnati, Ohio, in March, 1949. Her past history revealed two miscarriages prior to 1946, both at four months' gestation. A left salpingo-oophorectomy had been done elsewhere, in 1946, for an ectopic pregnancy. This admission was occasioned by menorrhagia. A dilatation and curettage revealed nothing significant. Thickening was felt in the left adnexal region. She had a normal delivery in January, 1950.

Three days following a normal labor and delivery on March 10, 1955, she experienced steadily increasing pain in the right lower quadrant. Blood and clots were passed vaginally. Examination revealed the patient to be in early shock. The uterus was palpable at the level of the umbilicus and was exquisitely tender. On the left side of



Fig. 1. Left arrow: Uterine vein and aneurysm sac. Middle arrow: Junction of ovarian artery and aneurysm. Right arrow: Ovarian artery.

the uterus was a strong thrill with a loud machinery type murmur, most suggestive of an arteriovenous aneurysm. The patient was observed and given transfusions.

The pain persisted, although to a lesser degree. The uterus remained quite tender. Arteriography was performed on March 15. This showed a tangle of somewhat dilated vessels over the pelvis. A small group of possibly abnormal vessels was seen extending just to the left of the fifth lumbar vertebra, but the connection with this group of vessels to the hypogastric artery or aorta was not clear. The uterine arteries were not demonstrated. On March 17, 1955, the thrill was no longer palpable but the bruit was still present. The patient recovered from this acute episode and was discharged on March 19, 1955.

Submitted January 17, 1957.

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The patient was watched carefully for regression of the thrill and bruit during involution of the uterus. The uterus involuted normally and the pain and tenderness disappeared. The thrill became palpable vaginally. In view of these findings, the patient was readmitted on May 22, 1955. Surgery was performed on May 24. The left ovarian artery and vein were greatly dilated. The vessels in the region of the left cornu of the uterus were also greatly dilated, as were the majority of the veins to the left of the uterus. The involved vessels were excised. (See figure 1.) Postoperatively, the patient did well and to date is well.

COMMENT

Arteriovenous fistulae are either congenital or acquired.[5] The congenital type probably result from a persistence of anastomotic channels. The acquired type usually follow trauma with a blunt instrument,[6] a penetrating wound, or operative procedures. The clinical findings are an audible bruit with a continuous murmur and a palpable thrill. Apparently, as a result of mass ligation as noted in the case presented here and in the foregoing references, A-V aneurysm may be a late sequela.

SUMMARY

A case is presented in which an arteriovenous aneurysm occurred nine years after surgery for an ectopic pregnancy and was precipitated by normal parturition.

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The Tuberculin Test*

ROBERT J. ATWELL, M. D.

THE tuberculin test is useful in clinical diagnosis, in epidemiological studies and in screening and case finding. In clinical medicine the value of this test as a diagnostic measure has great importance—importance which is all too frequently overlooked or neglected. Epidemiological data compiled by mass skin testing is well known. The tuberculin test as a means of screening or case finding has not been used extensively, but its value will probably increase in the future.

MATERIALS AND METHODS

There are two tuberculin test materials in common use today—(1) Old Tuberculin (OT) and (2) Purified Protein Derivative (PPD). OT is available as a concentrated solution which must be diluted for use. It is also available in prepared strips for use as patch tests. PPD is available in tablet form as PPD No. 1, intermediate and No. 2, and need only have a small amount of diluent added to prepare the test solution.

The common means of application of these materials is (1) by intracutaneous injection or (2) by patch test. The intracutaneous injection (Mantoux Test) is the most reliable and represents the only means of applying test material in a quantitative fashion. Although the patch test (Vollmer) is still in use where needles are objectionable, it is much less reliable and its use should be discouraged. In the use of solutions of OT and PPD the dose is 0.1 ml. intracutaneously. OT 1:1,000 dilution is roughly comparable to PPD intermediate.

Unless there is some reason to suspect excessive allergy, or if the patient has ocular or cutaneous tuberculosis, PPD intermediate or OT 1:1,000 are usually safe concentrations for the initial intracutaneous test. If the test is negative at these levels, PPD No. 2 or OT 1:100 should be employed. Tests should be read 48 hours after injection.

READING THE TEST

The tuberculin test is positive by any method *only* if induration of the skin is present at the test site. More extensive changes such as vesicles and sloughing may occur if too much tuberculin is applied. The presence of erythema alone has no significance. The extent of induration in millimeters is the best means of recording the reaction, leaving little room for confusion or question. The presence or extent of induration can best be determined by reflected light, by lightly running the finger over the test area or by lightly pinching the skin at the test site. Induration of 5 to 8 mm. or more constitutes a positive test with all test doses up to PPD No. 2 or OT 1:100. Occasionally with these higher concentration tests a minimal, nonspecific reaction may occur. The reason for these reactions is not clear, but in order to avoid error a reaction should be at least 8 to 10 mm. of induration with PPD No. 2 or OT 1:100 to be read as positive. The degree of positivity has very little clinical significance.

The Author

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INTERPRETATION

A positive tuberculin test means that the person has been infected at some time with the tubercle bacillus. A positive test gives no information regarding the activity of the infection. It gives no information of the duration of the infection except in infants where the infection could only have occurred following birth. In the latter case the younger the infant, the shorter the possible duration of the disease, and therefore the more likely it is to be active. Generally speaking, if tuberculous infection causes a pulmonary lesion, the tuberculin test will be positive at the time the lesion can be demonstrated by roentgenogram.

A negative tuberculin test may mean (1) that insufficient tuberculin was used to elicit a response or (2) the material was given subcutaneously or (3) that the person has never been infected with the tubercle bacillus. In terminal illness, overwhelming tuberculous infection, acute tuberculous pleurisy with effusion and in measles, a previously positive tuberculin test may become negative, but this is very unusual. Thus if the test material is given intracutaneously and the person is negative to PPD No. 2 or OT 1:100, the presence of tuberculous infection can essentially be eliminated as the cause of a pulmonary lesion.

APPLICATION

Thus, an adequately administered negative tuberculin test is a valuable diagnostic tool—it eliminates the possibility of tuberculous infection. Application of the skin test to screen contacts of patients with known tuberculosis is a more sen-

*This is one of a series of articles on chest diseases sponsored by the Ohio Trudeau Society, medical section of the Ohio Tuberculosis and Health Association.

Submitted September 16, 1957.

sitive index of infection than are roentgenograms, and a negative skin test in highest concentration essentially eliminates the need for x-rays in those contacts. Positive reactors, however, must be x-rayed for complete follow-up. It must be remembered, however, that a single skin test and a single roentgenogram are valid only for the day on which they are done and neither eliminates the possibility of infection the next day, the next week or the next month. To discover changes in a person's status regarding tuberculous infection, follow-up at least at yearly intervals is advisable.

The application of tuberculin testing to decrease the cost of screening by reducing the number of x-rays has been applied to medical students and student nurses for a number of years. It has been practical and valid. With the increasingly large number of persons in our population who have never been infected with the tubercle bacillus, the simple skin test will probably assume greater and greater importance and more widespread use. It is therefore wise to renew our acquaintance with it and use it more freely.

Symptoms and Findings in Secretory Otitis Media

The symptoms of secretory otitis media are loss of hearing, occasional tinnitus, autophony, and feeling of fullness or numbness. There is seldom pain and, when present, it is most likely due to an otic neuralgia. There is occasionally a feeling of fluid or crackling in the ear.

The drum head may be retracted. The head of the malleus appears lighter than normal in color, and the light reflex changes in shape and width and may be absent to clear. The thickness of the drum may range from normal or thin to thick and opaque in chronic cases. When the drum is not thick, the color may be bluish-gray or amber. When the middle ear cavity is partially filled, a fluid line may be present in a horizontal plane or may rise or dip from either side toward the malleus. In some cases, bubbles may be seen. Blocking and fullness may be intermittent at first, for a period of time, and then there may be blocking continuously. It may be sudden. The tinnitus may be intermittent at first and then become continuous. When intermittent, the prognosis for its correction is much better.

When the secretory otitis media is of long standing, with a thick, opaque drum, one can, under treatment, watch the drum get progressively thinner over a period of two months, indicating that there has been a thickening of the endothelium. This can be compared with the pathology present in hypertrophic rhinitis. Lederer believes that it is impossible to dissociate the mucous membranes of the pharynx, sinuses, eustachian tubes, and middle ear from one another.—A. O. Hendrickson, M. D., and W. O. Hendrickson, M. D., Wausau, Wis.: *Wisconsin M. J.*, 56:357, September, 1957.

Use of Colchicine in Treatment Of Acute Gouty Arthritis

When the clinical features suggest acute gouty arthritis, it is unnecessary to wait for the interpretation of the x-rays of the affected joints or the laboratory to report the urate level. Specific treatment, i.e., colchicine, should be instituted without delay. This preparation is the only specific anti-arthritic drug in the pharmacopeia, is indicated in gouty arthritis, and has no recognized action in the other types of joint disease.

The response to colchicine, when given orally, may be extremely helpful in confirming the diagnosis, as well as therapeutically in alleviating joint distress. Colchicine should be ingested regularly, 1.0 mgm. every two hours until the onset of gastrointestinal distress, be it nausea, vomiting or diarrhea. Usually the side action is apparent after the ingestion of not more than 4 or 5 mgm. of colchicine. At this time colchicine ingestion is to be discontinued and a gastric sedative prescribed such as tincture of camphorated opium, 5 cc. every two hours so long as is necessary. The pharmacologic action of colchicine remains an enigma nor do we have any explanation as to the need for prescribing sufficient colchicine to produce gastrointestinal distress. The empiric observation is well documented, however, and it is necessary to insist upon ingestion at periodic intervals until the onset of nausea, vomiting or diarrhea, if the full anti-inflammatory effect of colchicine is achieved. This method of administration as described constitutes a "full course."

Roentgenographic findings in gouty arthritis have received considerable attention but usually are negative in the earlier years of articular distress. It is a good policy to procure x-rays of the hands and feet as a matter of record but it would be exceptional if osseous tophi or cartilaginous changes were present early in the history of articular symptoms. After the disease has been apparent clinically for several years or more the characteristic punched-out areas in the epiphyseal portions of the joints, erosion of cartilage or diminution of joint space may be observed. It should also be noted that in some patients with well developed rheumatoid arthritis, cystic changes in the same areas of the hands or feet may be present. Rheumatoid arthritis usually is a diagnosis based upon clinical findings and the presence of a few punched-out areas of the bones suggestive of gout should not overrule the clinical presumption.

The presence of aural tophi should be investigated but the incidence is relative low. Subcutaneous tophi usually mean well developed gout with articular symptoms that have been present for a decade or more. The disease should have been recognized and brought under control before the development of subcutaneous tophi.—John H. Talbot, M. D.. Buffalo: *Connecticut M. J.*, 21:890, October, 1957.



TOPIC THIS MONTH:

Maternal Deaths* Involving Toxemia

CASE NO. 11

This patient was a 26 year old, white Para 0, abortus II, Cesarean I, who died 30 days post-cesarean section. No past history was recorded, except that she had had two abortions, one at five and one-half months, one at six months (?) respectively. There are no details concerning her prenatal care although it was said to be adequate; her last menstrual period was June 1 (estimated date of confinement March 8). The last pregnancy is stated to have been uneventful until the twenty-sixth week, when she was admitted to the hospital (December 1) because of "abdominal pain and contractions." Treatment consisted of bed rest, sedation and symptomatic therapy; no data are recorded concerning physical examination or laboratory tests. She was discharged January 4, supposedly well, but her physician apparently did not see the result of her last urinalysis revealing a 3 plus albumin.

On January 6 she was readmitted with *severe* abdominal pain, blood pressure 216/100, 4 plus albuminuria, and "generalized convulsions on admission." No other laboratory data were reported. She received magnesium sulfate and morphine which apparently controlled the convulsions. On January 7 her blood pressure was 140/90; a cesarean section was performed under spinal anesthesia, delivering a 2 pound living baby, indication: "convulsions." She was administered blood during the operation.

The following day the patient developed gross hematuria, and anuria. She was transferred to another hospital the same day (January 8) for dialysis by the artificial kidney. Details of her course are not recorded except that convulsions continued and the patient died February 8. Autopsy permission was granted.

Cause of Death: Eclampsia; anuria—transfusion.

Pathological Diagnosis: Eclampsia; bronchopneumonia, staphylococcus; abscesses, multiple, lung due to pneumonia; abscesses myocardium due to staphylococcus and sporotrichosis.

COMMENT

The Committee voted this case a preventable maternal death. Although the information on the case was meager, members felt the toxemia was not controlled. It appeared that a cesarean section should not have been done while the patient was still so ill from her toxemia, although laboratory and clinical studies are lacking to prove this point. Indications (also) for the transfusion which apparently contributed to her demise, were lacking.

CASE NO 59

This patient was a 21 year old, white primigravida, who died in her thirty-eighth week of gestation, undelivered, without labor. All of her past history was not known; she was believed to have had hypertension (?). Prenatal care (nine visits) considered inadequate because of lack of early vigorous therapy for hypertension. Last menstrual period November 1. Her blood pressure became elevated on or before the twelfth week (highest 190/120, lowest 142/88, usually reading 150/90). Therapy included salt poor diet, restriction of fluids and Serpasil® 25 mg., four times a day. Headache and edema appeared in thirty-seventh week; albuminuria appeared the thirty-eighth week. In her thirty-eighth week the patient was admitted to the hospital (July 27, 9 p. m.) ambulatory. Two hours later she became dyspneic and cyanotic; obstetric consultation was obtained at once. A cardiologist saw her at midnight.

Therapy included Cedilanid® 0.8 mg. intravenously, 500 cc. phlebotomy, aminophyllin, and an oxygen tent. Her blood pressure rose to 230/140; Unitensen® was given until it diminished to 180/110 (5 minutes). The dyspnea and cyanosis continued. Further medication included Cedilanid at 4 a. m., 250 cc. of 25 per cent glucose and 3¾ gr. aminophyllin without improvement. She pursued a downhill course and died at 4:30 a. m. on July 28. Autopsy was denied. Immediate post-mortem cesarean section delivered a stillborn fetus, 4 pounds, 5 ounces.

Cause of Death: Severe pre-eclampsia; congestive heart failure; hypertension; pregnancy 38 weeks, not delivered.

COMMENT

This case represents development of a severe, acute fulminating toxemia in a primigravida, superimposed upon a pre-existing hypertension, appearing early in, or even before, pregnancy. The Committee felt that the patient should have received intensive therapy when the hyperten-

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

sion was discovered, initially. Some clue as to the etiology of the hypertension might have been elicited through an autopsy. The futility of heroic therapy when signs of congestive failure appear is clearly demonstrated. The Committee voted this a nonpreventable maternal death.

CASE NO. 140

This patient was a 13 year old, Negro, primigravida who died four days postpartum. Her past history was not known; she received no prenatal care. At 6:55 p. m. February 5 she was admitted to the hospital, supposedly in her thirty-ninth week of gestation with toxemia, blurred vision and an estimated weight gain of 40 pounds. She was markedly obese (weight 200 pounds) and examination revealed a blood pressure of 152/112, marked edema, but no albuminuria. She was placed immediately upon medical treatment consisting of low sodium diet, fluids, sedation, ammonium chloride, and Apresoline.® Her response to therapy was very satisfactory.

On February 8 she went into labor spontaneously; after 15 hours of labor she was moved to the delivery room and given a saddle-block anesthetic (6 mg. Pontocaine®) by a physician. Shortly thereafter respirations ceased, pulse and blood pressure disappeared, obviously the patient was in profound shock with cardiac arrest. Within five minutes the chest was opened, cardiac massage was initiated and the heart began beating. Delivery of a stillborn fetus, *face* presenting (right mentum transverse) was accomplished by forceps rotation (to mentum anterior) over an episiotomy.

The third stage of labor was four minutes, followed by repair of the episiotomy; there was "no bleeding—no laceration." Respiratory obstruction developed; a tracheotomy was performed three hours postpartum. During the next few days extensive consultation was obtained; intensive supportive therapy was administered. The patient failed to regain consciousness and died February 13. Autopsy permission was obtained.

Cause of Death: Toxemia of pregnancy; cardiac arrest; tracheotomy; acute bronchitis.

Pathological Diagnosis: Toxemia of pregnancy with extensive characteristic eclamptic hemorrhagic necrosis of the liver; cerebral anoxic changes; hydronephrosis and pyelonephritis; acute bronchitis; tracheotomy, thoracotomy with secondary pleuritis.

COMMENT

With special interest in various features presented, the Committee deliberated on this case. The lack of prenatal care and extreme juvenile obesity with superimposed excess weight gain with pregnancy would indicate patient responsibility. On the other hand, the Committee felt hampered in evaluating the obstetrical management of the case because of a lack of data concerning (1) when the *face* presentation was *first* diagnosed, (2) what the status and condition of the cervix were at that time, (3) whether or not a needle was in the vein administering intravenous fluids when the saddle block anesthetic was administered.

Several members felt that although this case was undoubtedly one of *toxemia* pathology, available facts in the case suggested anesthesia as a predominant factor contributing to death of the patient. By a narrow margin, the Committee voted this a preventable maternal death (patient responsibility, P_1).

COMMENT OF CONSULTANT

The following comment of a consultant, who is a specialist in obstetrics and gynecology, was given at the request of the Committee.

Toxemia of pregnancy still remains as one of the leading causes of maternal death in this country. The importance of adequate prenatal care and supervision cannot be overemphasized as a prophylactic measure in its prevention. Once toxemia has developed, cure is not completely effected until the patient is delivered. Complications resulting from toxemia such as cerebral hemorrhage, thrombocytopenia, lower nephron nephrosis, cardiac failure, etc., should be anticipated, and measures instituted to prevent their occurrence.

Case No. 11: In support of the Committee's ruling of a preventable maternal death are the obvious preliminary warnings of impending danger. One month of hospitalization failed to give any record of physical findings or laboratory data to explain the cause of "abdominal pain and contractions." The appearance of albumin of this degree in the urine in the absence of edema and/or hypertension frequently signifies impending fulminating toxemia, and should demand immediate hospitalization for evaluation and treatment.

The timing and selection of method of delivery may be criticized, but from this history evacuation of the uterus was indicated. The indication for transfusion is not stated, and the need for a single transfusion is questionable in the absence of acute blood loss, shock, or severe anemia. (In the latter this should have been corrected during the previous month's hospitalization.)

Anuria could have resulted from blood incompatibility, but is not uncommon with fulminating toxemia, or severe placental abruption. With renal shut-down prompt attention to fluid and electrolyte balance may minimize complications and allow ample time for restoration of normal renal function.

Case No. 59: As obstetricians we should assume some responsibility in advising patients regarding advisability of pregnancy or continuation of pregnancy in the presence of medical illness that may be fatal. Toxemia occurs in 5 to 7 per cent of the average population. With essential hypertension toxemia will be superimposed in 25 to 35 per cent of cases. The dangers of cerebrovascular accidents, cardiac failure, and placental abruption is high in this group.

Patients demonstrating hypertension in the first trimester should be hospitalized for com-

plete cardiovascular-renal evaluation, and the added risk to the patient should be discussed with the patient and her husband. Development of symptoms of headache, abdominal pain, or visual disturbances, or the presence of edema, or albuminuria, while on outpatient therapy should suggest failure of therapy, and require hospitalization for more intensive treatment.

Three factors in this report cause me to disagree with the Committee's vote of a nonpreventable maternal death: (1) Patient had prenatal care considered inadequate by the Committee; (2) failure to hospitalize for evaluation of hypertension in the twelfth week or before, and (3) failure to hospitalize at the thirty-seventh week when headache and edema developed in the presence of standard antitoxemic therapy.

Case No. 140: This is an excellent example of toxemia developing in a primigravida with no prenatal care. Although the patient assumes the responsibility, it is still a matter of *education to the laity* that must be the *medical profession's responsibility.* In a large measure the formation and function of local, county, and state Maternal Mortality Committees have demonstrated a marked reduction in maternal mortality as a reward for their continuing educational program.

The problem of hypotension following spinal or caudal anesthesia is well known, and whenever administered, methods of combating these reactions should be immediately available. Shock followed by cardiac arrest may possibly result from sensitivity to or intravenous administration of the anesthetic agent. These complications of conduction anesthesia should not be forgotten. Actually, the Committee might well have considered two responsible factors in this case, both patient and physician, (P_1 and P_2).

Indications and Contraindications To Radioactive Iodine

Practically all workers in the thyroid field agree that radioactive iodine is the treatment of choice in recurrence of hyperthyroidism following thyroidectomy. It is likewise indicated in patients who are extremely poor risks or who have some disease complicating the hyperthyroidism. Likewise it will be indicated in patients who refuse operation.—Warren H. Cole, M. D., Chicago: *Texas State J. Med.*, 53:689, September, 1957.

ERRATUM

Through no fault of *The Journal* editorial staff, an incorrect statement appeared on page 1157 of the October 1957 issue. In the opening sentence of the last paragraph, left hand column, the wording was, "As was previously mentioned, in certain cases the materials were interchanged *with* the knowledge of the patients." The phrase should have read, "*without* the knowledge of the patients."

The Story Behind the Word

Some Interesting Origins of Medical Terms

Tyrosine—This is an amino acid which was discovered by the German chemist, Justus von Liebig, in 1846. It was obtained as a protein cleavage product from cheese and hence was named tyrosine from the Greek word "tyros," or cheese.

Vermis—A Latin word meaning a worm. The vermis of the cerebellum is so called from its worm-like appearance.

Vermin—A term derived from the French "vermine" which in turn comes from the Latin "vermis," a worm. By extension it has come to be applied to any kind of disgusting or hurtful small creatures, such as fleas, lice, ticks and mice.

Vater, Ampulla of—This is the dilatation at the junction of the common bile duct and the pancreatic duct. It is named after Abraham Vater, a German anatomist, who described this anatomical structure in 1720.

Vastus Muscles—There are four muscles which bear the name of vastus. They are: (1) the Vastus Medialis, (2) the Vastus Lateralis, (3) the Vastus Externus and (4) the Vastus Internus. These are all simple descriptive names with the terms vastus, meaning large and the second word of these names referring to their location. The Latin word "vastus" originally meant empty or unoccupied and was used to refer to a large, vast or immense space, such as a desert and hence by extension came to be applied to any large, vast or immense object.

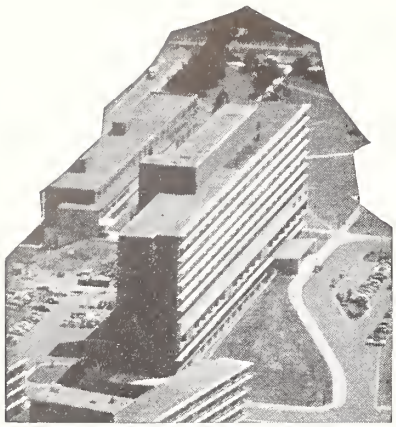
Varix—The Latin term, "varis, or "varicem" literally means a dilated or bent vein and is derived from the Latin word "varus," or bent.

Vagus—This is the so-called wandering nerve and was so named because of its extensive distribution. The word is derived from the Latin "vago" meaning to wander. The vagus nerve was described by Marcinus, a Roman anatomist, in about 50 A. D. Galen was also familiar with it. Domenico de Marchetti (1626-1688) an anatomist of Padua is generally credited with giving the name vagus to this nerve, which he described and divided into 16 parts.

Wheal—A descriptive term which is derived from the Anglo-Saxon word "wala" which was used to denote marks of stripes or blows such as are made with a cone or rod on the skin. The term was applied to skin lesions such as occur in nettle rash, in 1785 by Robert Willan, an English dermatologist. The term is now applied to the skin lesions of urticaria, serum sickness and other allergic conditions.

Welfare—Literally meaning "to fare forth and do well." It is derived from the Anglo-Saxon "well or weal," meaning good or better and "faran"—to go.

—Harry Wain, M. D., Mansfield, Ohio.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Ralph J. Johansmann, M. D., President

Presented by Perry Ayres, M. D., and Emmerich von Haam, M. D. Edited by Dr. von Haam

PRESENTATION OF CASE

THIS 31 year old white female was admitted to University Hospital because of cough and shortness of breath. Shortness of breath on exertion began 10 months ago and increased progressively. Six months ago her local doctor treated her for laryngitis and quinsy and told her at that time that she had heart trouble. She also had ankle edema, which disappeared after she received diuretics. She was started on digitalis, which she had continued taking until admission. She never complained of orthopnea or paroxysmal nocturnal dyspnea. She had had frequent episodes of syncope. Because of her increasing shortness of breath the digitalis was increased recently and four days prior to admission she began to suffer from nausea with vomiting.

Her past history included measles, mumps, chickenpox and pertussis. Eight years ago she had had a gallbladder attack with nausea, vomiting and epigastric pain but never had any recurrence. Review of systems revealed frequent frontal headaches which disappeared with rest. The patient was married and had had two normal pregnancies, 9 and 11 years ago.

PHYSICIAL EXAMINATION

The blood pressure was 90 over 60, the pulse 110 and regular, her body temperature normal. The patient was thin, seemed alert, responsive and appeared chronically ill. The skin showed a confluent macular rash over the flexor aspects of both upper extremities. The head was not remarkable. The fundi were normal. The nose, ears and throat were not remarkable. The neck was supple and the thyroid gland was not enlarged. The lymph glands were not enlarged. The breasts revealed no masses or tenderness.

The chest was resonant to percussion; there was a slight increase in the anteroposterior diameter and the breath sounds were decreased in intensity with an increase in the tactile fremitus. The heart was not enlarged to percussion. The heart sounds were distant and a short diastolic murmur could be heard in the left third interspace with a questionable third heart sound. The liver and spleen were palpable. The pelvic and rectal examinations revealed nothing remarkable. The neurological findings were normal. The lower extremities showed no edema.

LABORATORY DATA

The admission urinalysis revealed 20 mg. of protein, 2 to 4 white blood cells and 10 to 20 red blood cells per high power field. The red blood count was 5.46 million, the hemoglobin 16.4 Gm.; the white count was 14,000 with a normal differential count; the platelet count was 1,103,000. Antistreptolysin O titers were 125 and 166 units. C-reactive protein was negative and 1 plus. Serologic examination for syphilis was negative. The bone marrow was normal.

The fasting blood sugar was 122 mg.; 2 hour postprandial blood sugar was 152 mg. The blood urea nitrogen was 18 mg.; the total proteins were 6.9 Gm. with a serum albumin of 4.2 and a globulin of 2.7; the serum sodium was 148 mEq., the potassium 4.5 mEq. and the chlorides 107 mEq.; the van den Bergh test was .9 mg. direct, 1.8 mg. indirect; the thymol turbidity was 10; the cephalin flocculation was 1 plus. Lupus erythematosus cell preparation was negative. Sputum smear and culture were negative for acid-fast bacilli. A 24 hour urine specimen was negative for serotonin. An electrocardiogram was consistent with right ventricular enlargement with questionable right bundle branch block. The electroencephalogram was negative.

ROENTGENOGRAPHIC DATA

Fluoroscopy revealed cardiac enlargement, largely of the right ventricle, with enlargement

of the pulmonary artery segment and hypervascularity of the lung fields with slight increase in pulsations. X-ray examination of the chest showed the transverse cardiac diameter approximately 25 per cent above the expected normal. There was a straightness of the left heart border with prominence of the pulmonary artery segment. There was moderate pulmonary hyperemia, mainly in the medial part of the lung field. There was slight elevation of the right diaphragm which could have been due to an enlarged spleen.

Re-examination of the chest several days later showed a persistent moderate elevation of the right diaphragmatic leaf with some prominence of bronchovascular markings in the right lower paramediastinal region without appreciable change in the cardiac shadow or density of the lung parenchyma. There was no evidence of pulmonary atelectasis which could explain the elevation of the right diaphragmatic leaf.

PERIPHERAL OXYGEN SATURATION STUDIES

In blood from the left brachial artery with the patient breathing room air, the oxygen capacity was 19.3 to 19.38 per cent, the oxygen concentration 16.06 per cent, and the oxygen saturation 85 per cent. After she had received 100 per cent nasal oxygen for 10 minutes her oxygen capacity was 19.2 per cent, the oxygen concentration 18.29 per cent, and the oxygen saturation 95.2 per cent. Blood drawn from the right brachial artery showed an oxygen capacity of 19.7 per cent, an oxygen concentration of 15.39 per cent, and an oxygen saturation of 78.1 per cent. Blood drawn from the right femoral artery gave an oxygen capacity of 19.7 per cent, a concentration of 17.04 per cent, and a saturation of 86.5 per cent.

HOSPITAL COURSE

The usual management for the treatment of congestive heart failure was instituted. Cardiac catheterization gave right ventricular pressures at 140 over 16, a main pulmonary artery pressure of 135 over 75, and right atrial pressure of 16. The oxygen saturations of the blood at the time of catheterization varied from 22 per cent in the main pulmonary artery to 26 per cent in the right ventricle and right atrium and 30 per cent in the superior vena cava. Following catheterization the patient was febrile for approximately seven days.

She was treated with penicillin, 600,000 units twice daily, without response, but became afebrile after the administration of erythromycin. However, after approximately three days she began again to spike temperatures to 101°F. and from her twentieth hospital day she was continuously febrile until her demise. Approximately three days prior to death she developed swelling in the right leg and tenderness in the popliteal fossa suggestive of thrombophlebitis. On the morning of the twenty-sixth hospital day the patient experienced an episode of syncope and expired.

CLINICAL DISCUSSION

Dr. Perry Ayres: We are dealing with a 31 year old woman who seemed to have been quite well except for the usual childhood ailments, and a brief gallbladder attack eight years ago, until she developed shortness of breath and dyspnea approximately 10 months prior to her admission. A few months later a doctor told her that she had heart trouble. Her ankle edema responded to treatment with digitalis and diuretics; however her shortness of breath and cough apparently progressed. She finally developed nausea and vomiting and was admitted to the hospital. Presumably the nausea and vomiting represented signs of digitalis intoxication.

On admission she had a low systolic blood pressure, some tachycardia and no fever. She appeared chronically ill, but nothing is said about cyanosis or any distention of her cervical veins. The anteroposterior diameter of the chest was slightly increased, which is quite noteworthy for a 31 year old female with no history of any pre-existing pulmonary disease such as asthma. I defy anybody to explain to me that the breath sounds were decreased in intensity with an increase in tactile fremitus. Nothing is said about the quality of the mitral first sound or the relative intensity of the aortic first and second sounds. We can assume that there was no clubbing of the fingers.

THE LABORATORY WORK

The laboratory work is interesting. There was no albuminuria and a few red blood cells in the urine, no azotemia or uremia. The red blood cell count was slightly elevated and so was the hemoglobin, which I consider significant in a 31 year old woman who appears chronically ill. Women of this age ordinarily have a rather low count anyway, especially if they are mothers of two children, and when they appear chronically ill the count is almost always in the lower range of normal. I think we can conclude that this patient had a polycythemia. The platelet count was in the upper range of normal. She had a slight amount of icterus. The electrolytes, blood sugar and other blood chemistries were relatively normal.

An electrocardiogram was consistent with right ventricular enlargement and questionable right bundle branch block. This is the first indication that she had right ventricular enlargement since there is nothing reported on the physical examination. The cardiac fluoroscopy confirmed the enlargement of the right ventricle and hypervascularity of the lung fields with increased pulsations. No intracardiac calcifications were noted, nor is there any mention made of deviation of the barium-filled esophagus by the left atrium. There was considerable prominence of

the right pulmonary artery. The hilar shadow was slightly prominent but the vascular shadow in the periphery seemed not correspondingly increased. The lung fields except for the slight vascularity appeared pretty good. I feel that the elevation of the right side of the diaphragm was due to a large liver and I will stand on that and say no more about it.

I put a lot of thought into the oxygen saturation studies and I believe that we are probably dealing with a technical error, since I can't conceive of anything that would lower the oxygen saturation in the right brachial artery below that of the left brachial and femoral arteries unless there was a shunt directly from the pulmonary artery into the left subclavian artery, which does not seem very likely. The significant thing, however, is that the woman had rather markedly lowered oxygen saturation in her arterial blood. It was lowered to the upper limit of what we can ordinarily visually appreciate as cyanosis and I think we can therefore excuse the admission examiner, as I doubt if I would have seen it either. We do see cyanosis at a saturation level of 80 to 75 per cent. It is of great diagnostic significance that her oxygen saturation rose to 95.2 per cent after she had breathed 100 per cent oxygen for 10 minutes. That isn't as high as it ought to go, but considering that it showed quite a rise I believe this is an indication for a diffusion block in the lungs and not indicative of a shunt.

CARDIAC CATHETERIZATION

The cardiac catheterization showed something which we could probably have predicted from the physical examination if it would have recorded the intensity and quality of the pulmonic second sound. We know she had right ventricular hypertrophy. The pressure in her right ventricle was 140 over 16 and that in her pulmonary artery was 135 over 75—a striking elevation in both the systolic and diastolic pressures as compared to the pressure in her peripheral arteries of 90 over 60. So that if she would have had a shunt, she certainly would have had a beautiful setup for shunting blood from the right ventricle to the left. However, we cannot postulate a shunt because of what we have just learned about the oxygen saturation after she breathed pure oxygen. The right atrial pressure was somewhat elevated and identical with the diastolic pressure in the right ventricle, which seems good evidence of congestive heart failure. The oxygen saturations again were strikingly lowered and excluded in my opinion a left to right shunt.

So we can say that these tests revealed a marked decrease in the oxygen saturation of venous as well as arterial blood. There are the lowest figures I have seen in my experience, but when you consider that she is starting out with only somewhere around 75 to 80 per cent oxygen saturation in her arterial blood and that her blood is suffusing her tissues sluggishly and that therefore more than the usual amount of oxygen is being extracted from the already unsaturated blood, it is quite understandable that her venous blood would show such low concentration levels. However, it is a rather unusual finding.

After catheterization she developed a spiking fever which lasted until she died two weeks later. Three days prior to her death she developed symptoms of thrombophlebitis in her right leg but no anticoagulant therapy was used at this time because they could not find a vein. I wonder if all those veins had thrombosed, and I wonder also if she had thrombophlebitis after her cardiac catheterization, as people often do. Although multiple thrombosis might cause some fever, I suspect that she had something more than that, although we have no information about blood cultures or other symptoms of septicemia. All of a sudden she fainted and died on the twenty-sixth hospital day. She had fainted a number of times prior to her admission to the hospital after the onset of her respiratory symptoms.

SUMMING UP

In summing up this case I may state that I do not think that she had congenital heart disease unless it was a congenital cardiac enlargement secondary to some congenital defect in the pulmonary vasculature, and I doubt that. She might have had an atrial septal defect since that is the one form of congenital heart disease in which there may be little or no shunt. People with atrial septal defect, however, will usually have a pretty loud systolic murmur, maximal in the pulmonic area. I also think that I can rule out Eisenmenger's complex, which is the tetralogy of Fallot without pulmonic stenosis, because there was no shunt in spite of the presence of a tremendously elevated right ventricular pressure. With an overriding aorta and interventricular septal defect and a pressure in the right ventricle of 140 and in the brachial artery of 90, there should be some shunting from the right to the left ventricle and the low oxygen concentration in the blood would not respond to breathing of 100 per cent oxygen. I think therefore that she suffered from an acquired heart ailment.

We always have to consider mitral stenosis in cases like this even though the murmur of mitral stenosis was not heard. It could have been mitral stenosis but the objective evidence is not clear and consistent. Her pulmonary artery pressure was elevated considerably higher than it should be with mitral stenosis. Her oxygen saturation was probably lower than in cardiac failure from mitral stenosis, but that is a questionable thing. She had no left atrial enlargement. She was in advanced congestive failure presumably, as indicated by the high diastolic pressure in the right ventricle. She was in failure with tachycardia but had a regular sinus rhythm. That can happen with mitral stenosis, but the

majority of people with mitral stenosis who develop cardiac failure fibrillate. It is not a hard and fast rule, but we have to consider statistical probability to a certain extent.

Subacute bacterial endocarditis is a possibility but I think it is unlikely. Assuming that she did not have congenital heart disease, and also assuming that she did not have rheumatic heart disease, we would have a hard time finding a site for subacute bacterial endocarditis.

I think that her primary disease involved the pulmonary vessels and not the heart. I think she had either pulmonary endarteritis or pulmonary artery thrombosis leading to pulmonary hypertension, described as a rather loosely defined complex of symptoms called Ayerza's disease. We have a multiparous woman who might have had pelvic phlebitis, whose peripheral veins might have been thrombosed, and who terminally developed spontaneous thrombophlebitis in her lower extremities. Her number of platelets was at the upper limit of normal. I think that if we had a proper past history we might find that she had had several episodes of chest pain and cough, and she probably was one of those unusual examples of multiple repeated pulmonary emboli with diffuse obstruction of the pulmonary blood flow through small vessels and increase in pulmonary artery pressure with resultant cor pulmonale.

UNUSUAL SITUATION

I realize that I am talking about an unusual situation, but I think it fits the facts a little closer than anything else, including the development of her slight icterus. This icterus could have been due to the passive hyperemia of her liver with slight impairment of her liver function, but we also can see appreciable icterus from the hemolysis of the blood in patients with pulmonary or myocardial infarcts. I am not familiar with the pulmonary fibrosis of Hamman-Rich and there is not much evidence for it in the x-ray picture, but that condition would also be along the lines I am thinking about. It is always a good idea to rule out a collagen disease since periarteritis and polyarteritis have been reported in the pulmonary vasculature and some lesion like this could explain the pulmonary endarteritis which she may have.

After suggesting a diagnosis we should also explain why she died. People with chronic cyanosis and people with long-standing high pulmonary artery pressures are subject to syncope on the basis of cerebral anoxia. They also are subject to sudden death for the same reason, presumably on the basis of cerebral anoxia. Ordinarily we don't worry too much about embolization early in the course of acute painful thrombophlebitis in the lower extremities because we like to think that the clot present in the veins at that time is pretty well anchored by the inflammatory process to the wall of the vein, and the situation in which we do get massive pulmonary emboli is usually that of painless phlebothrombosis with very little inflammatory reaction in the wall of the vein.

There remains one thing, however, that I cannot explain and that is the fever that followed her cardiac catheterization. There is an old rule among clinicians that when you encounter fever in a case of heart disease you should think of infarction or infection of the heart and infarction or infection of the lung. I don't believe she had infection of the heart. I also think I am reasonably certain that a 31 year old woman of her constitution would not have an infarction of the heart. She could very well have had some bronchopneumonia. Why that should come on after cardiac catheterization I don't know. I think that fever is unexplained, but I think it is part of the thrombotic process that I believe was underlying her illness.

CLINICAL DIAGNOSIS

1. Cor pulmonale with congestive failure.
2. Pulmonary vascular disease with multiple thrombi, small infarcts and pulmonary hypertension (Ayerza's disease).
3. Chronic cholecystitis, probable cholelithiasis.
4. Acute thrombophlebitis of right leg.
5. Secondary polycythemia.

PATHOLOGIC DIAGNOSIS

1. Cor pulmonale with congestive failure.
2. Pulmonary fibrosis, diffuse, with chronic anoxia.
3. Pulmonary vessel thrombosis, old and recent.
4. Chronic cholecystitis and cholelithiasis.
5. Chronic pancreatitis.
6. Secondary polycythemia.

PATHOLOGIC DISCUSSION

DR. EMMERICH VON HAAM: I want to congratulate Dr. Ayres for his very good discussion, which practically hit the nail on the head. As far as Ayerza's disease is concerned, I agree with Dr. Ayres that it is an ill-defined disease which according to Anderson's *Textbook of Pathology* should be dropped from our medical dictionary. Ayerza himself described these cases as cases of pulmonary hypertension associated with pulmonary arteriosclerosis, but later cases of cyanosis with polycythemia and cor pulmonale as well as cases of pulmonary artery sclerosis, even without pulmonary hypertension, have been described as Ayerza's disease.

The body was that of a young, slightly plump woman measuring 63 inches in length and weighing approximately 120 pounds. The lips and nail beds were cyanotic, the neck veins were distended, and both lower extremities showed edema. The right pleural cavity contained 1,200 cc. of light yellow fluid. In congestive heart failure it is more common for a hydrothorax to develop on

the right than on the left side and it is thought that the enlarged heart may prevent the accumulation of fluid in the left pleural cavity. The heart was definitely enlarged and weighed 325 grams. The wall of the left ventricle measured only 9 mm. in thickness while the wall of the right ventricle was 8 mm. thick. That means that they were practically of equal thickness, which indicates a marked right ventricular hypertrophy which is compatible with a cor pulmonale. The valves were perfectly normal and there was no evidence of old rheumatic heart disease. No intramural thrombi were found and the coronary vessels were thin-walled and patent.

The lungs were slightly heavy and firm. The tissue appeared pinkish gray and hypoaërated. Several dark-red nodular areas could be noted from which sanguineous fluid could be expressed. Many small vessels were occluded by thrombi. The bronchi and the trachea were normal.

The liver appeared congested but otherwise normal. The wall of the gallbladder was thickened and injected. It contained a medium-sized mixed gallstone. The gastrointestinal tract and the pancreas were normal. The kidneys were congested. The uterus seemed to be normal. Exploration of the pelvic veins and the saphenous veins revealed no thrombi which could have been the source for pulmonary embolism.

MICROSCOPIC EXAMINATION

Sections through the right heart muscle showed marked hypertrophy of the muscle fibers. Sections through the lungs showed a diffuse interstitial proliferation of fibroblasts with intra-alveolar accumulations of alveolar cells. There were small focal pulmonary infarcts and many small vessels showed marked endothelial swelling with thrombosis. The picture resembled that described by Hamman and Rich with the exception of the complicating vascular changes. Sections through the gallbladder and pancreas showed chronic inflammation. The remaining microscopic examination was not significant.

In conclusion then we can say that this patient had a disease which led to pulmonary hypertension and cor pulmonale. The basis of the disease I believe was a diffuse pulmonary fibrosis probably of viral origin complicated by multiple pulmonary vessel thromboses.

GENERAL DISCUSSION

DR. AYRES: I do not know how we could have predicted the pulmonary fibrosis since we had no direct evidence of it clinically. The only evidence we had was the indirect evidence of cor pulmonale, and diffuse pulmonary fibrosis is one of the conditions that causes cor pulmonale. You might ask why pulmonary function studies were not done and if they had been done would they have given us an answer? I think probably not. This woman was in failure and you would not have been able to rely on pulmonary function studies if she had been able to cooperate well enough to have them done.

Her cor pulmonale of course is secondary to her lung disease and that lung disease may be almost any chronic lung disease, but it is always associated with fibrosis. I know very little about this unusual form of diffuse fine fibrosis as Dr. von Haam has demonstrated. I think it was the cause for the air diffusion block mentioned previously. We should think occasionally of what air has to go through to get into the blood. It has to go through the alveolar basement membrane, it has to go through the capillary basement membrane and the fibrous tissue and interstitial fluid between these two and that is an appreciable distance for gas to diffuse. Whenever the distance between the alveolar membranes and the alveolar capillaries is widened by fluid, by fibrous tissue, the blood circulating through the lungs is not able to pick up as much oxygen.

As regards the role of her chronic pancreatitis in the production of multiple thrombi, I can't say very much. Certainly we know that migratory thrombophlebitis is common in carcinoma of the body and tail of the pancreas and that chronic pancreatitis is associated with a thrombotic tendency.

QUESTION: How do you account for the diastolic murmur?

DR. AYRES: The diastolic murmur is like that called Graham Steell murmur in mitral stenosis. Any situation which will elevate the pressure in the pulmonary artery may dilate the ring of the pulmonary valve so that the blood can leak back during diastole.

QUESTION: How do you explain the absence of x-ray findings?

DR. MOLNAR: With multiple small pulmonary emboli there are usually no findings in the x-ray fields. Evidences of pulmonary hypertension are prominent pulmonary vessels in the hilar areas, a prominent pulmonary artery and right ventricular hypertrophy. In extensive pulmonary fibrosis of the idiopathic type, the Hamman-Rich type, the x-ray findings are usually striking. From the x-ray picture alone, her principal lesions are the vascular changes and not the pulmonary fibrosis.

Industrial Poisoning

Misdiagnosis of diseases as due to industrial poisoning leads to much misunderstanding, higher taxes and insurance rates and "compensation neuroses." It is important to know the concentration of the suspected poison and its specific effects in order to logically indict it as the cause of illness. Examples discussed to illustrate some of the pitfalls of diagnosis in industrial medicine are methylbromide, carbon monoxide, ozone, oxides of nitrogen and of sulfur, hydrogen sulfide, benzene analogs, boron and fluorides.—C. H. Thienes, M. D., Pasadena: *California Med.*, 87: 135, September, 1957.

Warning To All Members!

Your Membership in the Ohio State Medical Association and American Medical Association, Including Subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA*, Will Expire on December 31. Here's How To Renew Them:

It's time for all members to pay 1958 membership dues—local, state and national—unless in an exempt classification.

Mail your check immediately for dues to the Secretary-Treasurer of Your County Medical Society.

OSMA dues are $25.00. AMA membership dues are $25.00. If you don't know the amount of your County Medical Society dues, check with your local Secretary-Treasurer.

Many members probably will want to send one check to cover local, state and national dues. Make Check Payable To Your County Medical Society. If you do tender a separate check for AMA dues, make it payable to your County Medical Society and mark on the check the words, "For 1958 AMA Dues."

Your local Secretary-Treasurer will forward state and national dues for you and other members to the Columbus Office of the OSMA. That office will transmit AMA dues to Chicago.

Remember: As a part of the privileges and services offered to all members of the OSMA and the AMA, you will receive a year's subscription, without extra cost, to *The Ohio State Medical Journal* and *The Journal of the AMA*—or some other AMA publication of your own choosing.

Memberships and subscriptions are on a calendar year basis. Both expire on December 31. Renewal must be made by January 1, 1958, to keep them current.

Members who were exempt from paying OSMA or AMA dues, or both, in 1957 will be carried over automatically on the 1958 membership roster of both organizations unless their status has changed.

Want Jenkins-Keogh Bill? . . .

Better See or Write Your Congressman about It Now: Hearings To Start January 7: Measure Explained by Congressman Jenkins

SHORTLY after the Congress reconvenes in January, 1958, the Ways and Means Committee of the House of Representatives will start hearings on the Jenkins-Keogh Bills H. R. 9 and H. R. 10—the measures which would permit income tax deferment on a part of the premiums paid by self-employed persons, including physicians, for retirement insurance.

Ohio physicians, assuming that they would like to see this idea become law, should get in touch immediately with their respective members of the House and with Senators Bricker and Lausche and urge them to support the proposals.

Ohio members of the Ways and Means Committee is Congressman Thomas A. Jenkins, Ironton, one of the co-authors of the bills.

STATEMENT BY JENKINS

Physicians will be interested in reading the following excerpts from a statement by Congressman Jenkins on the Jenkins-Keogh Bills as published in the Congressional Record and they should save this piece for reference when discussing the bills with their Congressman. Said Mr. Jenkins:

"Mr. Speaker, I dare say that every Member of the House has received letters with reference to the Jenkins-Keogh bills. Many of you have received dozens of letters, many of you have spoken to me about these bills. I want to say at the outset that many of the intelligent people of the country favor the passage of one of these bills.

"Our existing tax structure contains a regrettable discrimination against self-employed taxpayers in that they are denied the tax benefits accorded to employees generally for their retirement.

"Under existing law a general employee is not taxed on amounts paid by a corporation for the establishment of a retirement fund with respect to the employee. The employee does not become subject to tax until he begins to draw his retirement benefits.

DISCRIMINATORY FEATURES

"A self-employed person does not have a similar opportunity to defer his tax liability on amounts set aside for his retirement. The doctors and the lawyers and thousands of other self-employed are interested.

"There are several disadvantages in this discriminatory aspect of our Federal tax structure.

"The first of these is the fact that this discrimination results in an inequitable apportionment of the total tax burden among our citizens.

"A second disadvantage is found in the fact that existing law with its onerous schedule of tax rates virtually precludes the self-employed individual from making any realistic provisions for his years of retirement.

"A third disadvantage of the present law treatment of self-employment income is that it prevents the accumulation of investment savings that is vital to the industrial and technological development of our Nation.

"Mr. Speaker, there is legislation pending before the Congress that would remove the discrimination I have referred to.

"I refer to "The Self-Employed Individuals' Retirement Act of 1957," H. R. 9 and H. R. 10, introduced by my distinguished colleague from New York [MR. KEOGH] and myself.

PROVISIONS OF BILL

"Mr. Speaker, simply stated this legislation would allow self-employed individuals to exclude amounts up to 10 per cent of their otherwise taxable income in computing their tax liability, provided such amounts are invested in prescribed types of retirement funds, annuities, and insurance contracts.

"These bills would provide an annual maximum deduction of $5,000 and a lifetime maximum deduction of $100,000.

"Appropriately the bills would allow a somewhat larger annual deduction for individuals who are age 50 or over at the time the legislation becomes effective.

"The amounts excluded from tax would become subject to tax as they are withdrawn after the taxpayer reaches 65 and retires.

"From this brief description of the legislation it is evident self-employed individuals from all walks of life would receive deserved benefit from the enactment of this legislation.

"Examples of specific economic groups that would be benefited are farmers, self-employed businessmen, physicians, lawyers, and other self-employed individuals.

OBJECTIONS NOT VALID

"The principle embodied in the so-called Jenkins-Keogh proposal has been pending before the Congress of the United States for years. I believe it is proper to state that there is general agreement that the principle is sound but objection has been raised to the legislation on the grounds that its enactment would entail a revenue loss.

"The Treasury has felt obligated to oppose the legislation, under both Democrat and Republican administrations. However, with the modest im-

provement in the fiscal affairs of our Nation that has occurred in recent years I believe that the time is at hand when the Congress can and should take favorable action on the Jenkins-Keogh proposal.

"It is my hope that this prospect will become reality during the 85th Congress and will be made possible through substantially reduced Federal expenditures and enlargement of the budgetary surplus.

"It is my hope that across-the-board tax reduction fairly granted to all our taxpayers will be possible and that an important part of such a tax reduction program will include the provisions of the Jenkins-Keogh bills.

"It is a matter of simple justice for the 10 million American citizens who are the victims of this discrimination in our present tax structure that this result should be realized without delay.

HEARINGS START JAN. 7

"This legislative proposal will undoubtedly play an important part in the revenue revision hearings scheduled by the Committee on Ways and Means to begin January 7, 1958. I am confident that when the legislation is presented to the House of Representatives for a vote that it will receive the overwhelming support of the distinguished membership of this great legislative body.

"If the employees of the country are taken care of in this respect why should not the men who employ them be given some protection?

"Mr. Speaker, this legislation represents tax fairness and tax equity. It represents principles that are consistent with our American way of life. It represents in my judgment must legislation for favorable action during the 85th Congress."

Cleveland Academy Executive Secretary Accepts Post in Miami, Florida

M. John Hanni, Jr., executive secretary of the Academy of Medicine of Cleveland since 1953, has announced his resignation from that post effective the end of the year. He joined the staff of the Cleveland Academy in June, 1953, and was appointed executive secretary when H. Van Y. Caldwell retired effective December 1 of that same year. Mr. Caldwell is now living in Chatham, Mass., on Cape Cod.

Hanni has accepted appointment as executive secretary of the Dade County (Florida) Medical Society, with offices in Miami, effective January 1. He succeeds in that post John C. Lee, who has accepted a similar post with the Harris County Medical Society in Houston, Texas.

Hanni is a graduate of Ohio Wesleyan and received his master's degree from Western Reserve. He is a veteran of World War II, having served with the Air Force.

A successor for the Cleveland post has not been selected.

Eisenhower Asks More Private Funds for Medical Schools

President Eisenhower, in a major address October 22 to the National Fund for Medical Education, issued a call for business and community leaders, along with the general public, to help medical schools pay their bills. The President did not mention the administration's pending bill for federal construction aid to medical schools, although there is no indication it will not be pushed in the next session of Congress.

Implicit in Mr. Eisenhower's New York address is the need for increased voluntary efforts before turning to the Federal government. "For government to take over all responsibility in this critical field would signal the onset of a grave inflection of our nation's spirit," the President told his audience of corporation executives, medical school educators and others interested in health matters.

132 Per Thousand Population Admitted To Hospitals Last Year

The ratio of hospital admissions to population in the continental United States outstepped the total population increase in the 11-year period 1946-1956, according to the annual report on hospital statistics published in the Guide Issue of *Hospitals*, journal of the American Hospital Association.

Admissions to hospitals of all types in 1956 were 22,089,719, or 132 per thousand population. In 1946 the rate was 112 per thousand population.

The hospital statistics released were compiled from questionnaires sent to 6,966 hospitals listed by the American Hospital Association in its annual directory of hospitals.

The 6,966 hospitals in the continental United States had 1,607,692 beds and an average daily census of 1,355,792 in 1956. Of these hospitals, 51 per cent were nonprofit, 17 per cent proprietary, 6 per cent federal and 26 per cent state and local governmental hospitals.

The voluntary nonprofit hospitals led in number of admissions—nearly 15-million in 1956. Over 4-million admissions were to state and local governmental hospitals. Proprietary and federal hospitals each accounted for about 1.5-million admissions.

Of the average 1,355,792 patients in hospitals on any given day in 1956, 62 per cent were in state and local governmental hospitals, 24 per cent in nonprofit hospitals, 12 per cent in federal hospitals, and 2 per cent in proprietary hospitals. The large percentage of patients in the governmental hospitals each day reflected a high proportion of psychiatric and tuberculosis institutions providing predominantly long-term care.

Although less than 2 per cent of all admissions were to psychiatric hospitals in 1956, 53 per cent of all patients in hospitals on any given day were in psychiatric institutions.



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NEW DOSAGE. The recommended adult dose is 1 Gm. (2 tablets or 4 teaspoonfuls of syrup) the first day, followed by 0.5 Gm. (1 tablet or 2 teaspoonfuls of syrup) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

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1. Nichols, R. L. and Finland, M.: *J. Clin. Med.* 49:410, 1957.

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*Reg. U. S. Pat. Off.

Responsibilities of Medical Staff . . .

Organization and Functions of Staff Also Covered in Bulletin Issued by Hospital Accreditation Commission: Another in Series

THIS article, another in a series on hospital accreditation, covers the responsibilities, organization and functions of the medical staff of a hospital.

It is based on a bulletin issued by the Joint Commission on Hospital Accreditation.

* * *

The governing body of a hospital must obviously delegate the responsibility of medical functions to the medical staff. Only the medical staff can assume responsibility for the quality of medical care rendered to patients. In order to fully carry out this responsibility it is incumbent on every medical staff to be self-appraising and self-regulatory. Although the methods and procedures used to accomplish this must be determined by the local hospital staff, they must be predicated on fundamental principles and controls which cannot be ignored by any hospital medical staff.

ANALYSIS AND REVIEW

The Standards for Hospital Accreditation of the Joint Commission on Accreditation of Hospitals places on the medical staff the responsibility for constant analysis and review of the clinical work done in a hospital. The following help the staff to carry out this responsibility:

1. Selection of those physicians recommended for staff appointments and hospital privileges.

The selection of physicians to be recommended for medical staff appointments should be based on the following principles:

a. A license to practice medicine is not a guarantee of competence in any field. All that it confers is a legal right—not a moral right.

b. Privileges should be extended to all qualified physicians to practice in the hospital in the fields of general medicine, surgery, pediatrics, obstetrics, gynecology and other specialties according to experience, judgment, ability and competence as evaluated by the Credentials Committee and recommended to the Staff and to the Board.

c. Individual merit and competence should be the sole criteria for selection, and under no circumstances should the accordance of staff membership or professional privileges in a hospital be dependent alone upon certification or membership in specialties societies.

SCOPE OF PRIVILEGES

In advising the governing body concerning the appointment of a physician, the medical staff should indicate the scope of privileges which should be accorded to him. To guide the Credentials Committee or those assigned this function, the bylaws, rules and regulations of the medical staff should define and delineate privileges. This is a difficult task and can be done only at the local level. Some hospitals use cards purchased from medical record companies. Smaller hospitals frequently define major and minor privileges in medicine, surgery, and obstetrics and gynecology and the privileges of an individual physician are determined in each of these three major services. Granting privileges is a grave responsibility and must be thoughtfully and carefully carried out. Staffs and hospital boards should remember the Ohio Supreme Court decision "Where a public charitable hospital failed to exercise due and reasonable care in the selection of physicians . . . and injury results from the incompetence or negligence of such persons, the hospital is liable." When a physician has been appointed, the privileges granted to him should be on file in the office of the hospital administrator. In the case of surgical privileges, a duplicate copy should be on file in the operating room.

EFFECTIVE ORGANIZATION

Constant analysis and review of the clinical work done in the hospital can be carried out only by effective organization of the medical staff with each member assuming his share of responsibility. It means real down-to-earth leadership and planning, often taking considerable time, resulting occasionally in loss of both patients and income. Accepting a staff office and committee membership is not just a paper honor; it means accepting responsibility for thoughtful conduct of executive and administrative affairs and dedication to high standards in maintaining quality patient care.

Effective medical staff organization implies able officers, functional bylaws, rules and regulations and actively working committees. The control of professional work can come only from a conscientious staff which at all times keeps the welfare of the patient foremost in mind in all its deliberations.

IMPORTANT COMMITTEES

The committees most directly concerned with the review of patient care are:

a. **Medical Records Committee**

The Medical Records Committee supervises and appraises the quality of medical records to insure their maintenance at or above the required standard. The word quality is the keyword. It is true

that the committee member checks for completeness, accuracy and delinquency, but as he reads each chart his comment to himself should be, "I believe that this case was well handled so far as the documentary evidence is concerned and if it becomes necessary for another physician to continue the case, he could carry on from this chart without detriment to the patient."

b. Tissue Committee

The Tissue Committee studies and reports to the staff or to the Executive Committee of the staff on the agreement or disagreement among the pre-operative, post-operative and pathological diagnoses and on whether the surgical procedures undertaken in the hospital were justified or not. This study also includes those procedures in which no tissue was removed. The keyword is justification and it has many connotations. The committee member in reviewing the case asks himself, "Was this operation necessary? Was the case properly worked up? Was the timing good? Was the operation adequately performed? Was the entire handling of the case adequate and sufficient?

c. Credentials Committee

The Credentials Committee reviews applications for appointment and reappointment to all categories of the staff. They delineate the privileges to be extended to the applicant and make appropriate recommendations to the staff.

STAFF MEETINGS

Meetings of the staff are an important tool in the evaluation of clinical work. Staff and departmental meetings are held for the purpose of reviewing the medical care of patients within the hospital and those recently discharged and not for the presentation of scientific papers or discussions. It is here that the staff learns of the activities of the departments and committees and formulates policies and procedures to keep patient care at a high level. Only by being aware of what is currently being done can any conscientious hospital staff hope to improve its results and build up additional skills. So that there is a record of what transpires, minutes of discussions of medical meetings should be concisely recorded and reveal a thorough review and analysis of the clinical work done in the hospital.

MINUTES

Minutes of meetings should give evidence of the following:

a. A thorough review of the clinical work done by the staff on at least a monthly basis. This includes consideration of selected deaths, unimproved cases, infection, complications, errors in diagnosis, and results of treatment.

b. Consideration of the hospital statistical report on admissions, discharges, clinical classifications of patients, autopsy rates, and other pertinent hospital statistics.

EDITOR'S NOTE: At the 1957 Annual Meeting of the OSMA, the House of Delegates instructed *The Journal* to publish material on hospital accreditation. The first article of a series on this subject appeared in the August issue, explaining the principles underlying the work of the accreditation commission. The second article in September dealt with recommendations of the AMA Stover Committee; the third in October, with medical staff meetings; the fourth in November, with medical records. This is the fifth article.

In subsequent articles as information is available *The Journal* will present suggestions and information from the Joint Commission and answers by the Commission to many varied questions on the activities of the Commission, standards set, hospital administrative problems, etc.

c. Roll call of those in attendance and those absent whose cases were discussed.

d. Medical record number and date of admission of the cases discussed.

e. Names of discussants.

f. Duration of the meeting.

STAFF DIVISIONS

Division of the staff into services or departments to fulfill medical staff responsibilities promotes efficiency and is recommended in larger general hospitals. Functional Division of the medical staff into more than the minimal medical and surgical services is frequently desirable. It is necessary that each autonomous service or department be organized and function as a unit.

Since the General Practice Department is not a clinical entity, the responsibilities of this department are not those of a clinical service. Because misinterpretation of the Standards relating to general practice departments continues; the Commissioners of the Joint Commission on Accreditation of Hospitals wish to reaffirm their stand on this matter.

GENERAL PRACTICE DEPT.

a. The responsibilities of this department shall be limited to administration and education. It shall not be a clinical service and no patients shall be admitted to the department. If and when desirable, however, the department may be made responsible for conducting the outpatient clinic in whole or in part.

b. Since the Department of General Practice will not have a separate service, the members of the General Practice Department shall have privileges in the clinical services of the other departments in accord with their experience and training, on recommendation of the Credentials Committee. In any service in which any general practitioner shall have privileges, he shall be subject to the rules of that service and

subject to the jurisdiction of the chief of the clinical service involved.

c. The medical staff should give to the General Practice Department such administrative responsibilities in the conduct of medical affairs as are desirable to meet the needs of the hospitals.

d. The Joint Commission endorses and recommends that Departments of General Practice be established in hospitals where the size of the hospital and the educational facilities make such an organization possible and feasible.

e. Any action to create a Department of General Practice should be initiated by the generalists on the staff of a given hospital.

f. A General Practice Department should have fair and equitable representation in all staff activities of the hospital.

g. A generalist should be granted hospital privileges according to his training, ability, and demonstrated competence.

h. A well functioning General Practice Department in a hospital is considered an attribute by the Commission.

MATTERS OF POLICY

A physician when accepting a hospital appointment, assumes responsibility for supporting medical staff and hospital policies. He becomes a creative force in formulating future policies and standards of patient care. He works through the staff organization to maintain high standards. He supervises those less experienced and accepts supervision from those more experienced. He accepts controls as a protection to himself as well as to others. He contributes to the team-work required in the modern practice of medicine. He makes it possible for the medical staff to be truly self-appraising and self-regulatory.

Ohioans Are Named To Positions in American Heart Association

Three Ohioans were honored at the annual meeting of the American Heart Association, October 25-28 in Chicago.

Dr. A. Carlton Ernstene, Cleveland, was elected one of the vice-presidents of the organization. He was one of the founders and served as first president of both the Cleveland Area Heart Society and the Ohio State Heart Association. He also has served as chairman of the AHA's section on clinical cardiology and has been a member of the board of directors since 1953.

Irving B. Hexter, Cleveland, was re-elected as one of the vice-presidents, and received the association's Gold Award for voluntary work in the fight against heart disease.

Walter S. Page, Jr., Columbus, executive secretary of OSHA, was named president-elect of the Staff Conference of the American Heart Association. The Conference consists of staff members of the national, state and local heart associations throughout the country.



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The Doctor and Adoption . . .

Knowledge of State Laws and Prescribed Procedures Is Important To Physician in Assisting in Adoption or Placement of Children

FREQUENT inquiries at the OSMA state headquarters concerning adoption procedures indicate that Ohio's physicians will find it valuable to obtain a working knowledge of Ohio's adoption laws and procedures.

This knowledge should include not only the laws and procedure for a couple adopting a child, but also the laws and procedure in assisting a mother in finding a home for an infant.

For the purpose of informing OSMA members, discussions were held with official adoption agencies to obtain the latest information on adoption laws and policies. This article deals with the more pertinent points of law and the value of following certified channels in adoption and child placement.

Regardless of the fact that the physician who assists in either adoption or placement has the best of intentions, failure to follow procedures prescribed in the state code can place him in jeopardy since the law provides penalties, including fine and imprisonment, for such violations.

STATE LAW SPECIFIC

It is of paramount importance for the physician to remember that, under Ohio law, a child less than two years of age may be placed for adoption only by a juvenile court or a certified child caring organization, thus making it necessary for the court or agency to obtain legal custody of the child.

The mother may, through a juvenile court hearing, surrender her child to the agency, or she may surrender it to the agency through a properly executed, permanent, legal release. In either case, her name does not appear on an adoption petition, and her identification remains secret.

After the agency obtains proper legal custody, it may place the child in the foster home selected. The law provides for six months' residence in the adoptive home before final adoption is granted. However, some agencies and adoptive parents prefer to wait a year.

The code makes it unlawful for any persons, organizations, hospitals or associations not approved and certified by the Department of Public Welfare's Division of Social Administration knowingly in any manner to become a party to the separation of a child from its parent, parents or guardians, except through the procedures established by the code.

THE OLDER CHILD

For the older child, the parents, parent or guardian may make an agreement with an approved agency or institution surrendering temporary or permanent custody of the child to the agency, and in the agreement may authorize the agency to appear in any proceeding for the legal adoption of the child, and consent to its adoption.

When such an agreement is executed, an adoption order by the judge is binding on the parents as if they personally were in court and consented to the adoption.

CONSENT TO ADOPTION

Written consent to the adoption is required as follows:

(1) By the child, if over 12 years of age;

(2) By each of the living parents, adult or minor, except (a) the unmarried mother, who may be considered the sole parent, (b) parents who have been permanently deprived of custody, or have been adjudicated incompetent by reason of mental disability, (c) parents who have been determined by the juvenile court of the county in which the child resides to have wilfully neglected the child for more than two years:

(3) Guardian of the child;

(4) The department or organization holding permanent custody of the child.

INVESTIGATIONS REQUIRED

If the probate court finds that the placement of the child has been illegally made and not in accordance with the provisions of the code, the case may be referred to the juvenile court for investigation of the placement. If the juvenile court approves the placement, adoption goes forward; otherwise, the juvenile court retains jurisdiction and responsibility for care of the child.

A husband and wife jointly, a step-parent married to one of the natural or legal parents of the child sought to be adopted, or any other proper person may petition the probate court of the county in which the petitioner resides or of the county in which the child was born or has legal settlement or residence, or has become a public charge, for leave to adopt a child and for a change of the name of the child.

The code has provisions for investigative procedures, early hearings on adoption petitions, visitations to the adoptive home following the interlocutory order, and rights of privacy.

DETAILED PROCEDURES NECESSARY

While such laws may have what appear to the adoptive parents as endless red tape and delay, they are designed to protect all parties involved

—the child, the adoptive parents, the party surrendering the child, and the agency.

Welfare agencies have ample records proving that placement of children hurriedly and illegally, without adequate investigation and evaluation, often results in considerable regret and difficulties.

The parents who adopt a child outside of the prescribed procedure can never be certain that the natural parent or parents cannot regain custody of that child.

It is not impossible that the unwed mother, for example, who places her baby soon after birth and outside of the proper legal steps may have a change of heart and institute action to regain custody of her child. She has a fairly strong argument for her side.

PROPER STEPS VITAL

Moreover, the physician who has a role in the illegal placement of a child, regardless of how good his intentions, may be jeopardized since the law provides strict penalties, including fine and imprisonment, for anyone involved in unlawful placement of children under two years of age. For his own protection as well as his social responsibility, the physician should refer the unwed mother-to-be or the prospective adoptive parents to a certified child welfare organization. If the girl is not able to make the contact herself, the physician should seek her permission to make the contact for her.

If the girl is undecided as to what she wants for the baby, arrangements can be made in many communities for temporary care of the baby until she makes her decision.

CLEARING SERVICE

Child Welfare Services, Division of Social Administration, Department of Public Welfare, can provide a list of certified public and private agencies engaged in child placement and adoption. Also, the service acts as a clearing house for the more than 120 certified agencies.

This clearing service operates for the benefit of local agencies who are unable to provide a child for qualified, prospective adoptive parents. Any agency unable to provide the applicant parents with a child may refer the matter to the state clearing service, which in turn provides other local agencies with the necessary information concerning the parents. This enables the local agencies to compare this information with children they have for adoption. This is important, for successful adoption requires not only the right child for the parents, but also the right parents for the child.

A physician may obtain the names of certified agencies in his area by writing the OSMA headquarters office or the Child Welfare Services, Division of Social Administration, Department of Public Welfare, Oak Street at Ninth, Columbus 15.

The placement of a child with proper adoptive parents is the ultimate purpose of any adoption program. For this reason, adoption procedures, investigation and visitation are what may seem to be exhaustive.

Physicians desiring more specific information on adoption or child placement may obtain it by writing to OSMA headquarters in Columbus.

SUMMARY

It is the responsibility of physicians to familiarize themselves with good adoption practices and to cooperate with ethical and certified child-placing agencies.

Adoption should be resorted to only after it is determined that it is impossible for one or both parents to maintain the child properly.

Placement of the child should be made only after thorough investigation, social, mental and physical, of both the child and the parents.

No child should be placed for adoption if careful study indicates it to be unsuitable for adoption. Just as in all other cases, child welfare agencies should be consulted in instances involving children with unusual problems.

No legal adoption should be permitted until a probationary period establishes satisfactory parent-child adjustment.

Physicians who have a role in improper adoption or child placement leave themselves liable for court action.

Program Started To Relieve Shortage of Cadavers

A six-part program has been proposed by a committee of the National Society for Medical Research to relieve the increasingly serious shortage of cadavers threatening the quality of medical education in the United States.

"A majority of medical colleges report that they are unable to obtain enough bodies to teach student doctors efficiently," Dr. Oliver P. Jones, head of the anatomy department at University of Buffalo Medical School and chairman of the committee said. "Some schools have been forced to drop such important courses as surgical anatomy."

SIX-POINTS ENUMERATED

The committee's program includes:

1. A survey of public opinion toward anatomical studies.
2. A series of conferences with religious leaders, public welfare administrators, undertakers, hospital superintendents and other persons concerned with the disposition of bodies.
3. A program of education for persons in the health professions.
4. A general public educational program.
5. The drafting of modern laws making bodies available through bequest (in 39 states, a person's body is not his own to give after death).
6. Legal reference service, with standardized forms and procedures for bequeathing a body to a medical school.

Tax Roundup for Physicians . . .

Federal Income Tax Is One of Several Assessments on Which Doctors Must File Returns and Pay; Here Is How To Comply with the Tax Laws

WITH the coming of 1958, physicians will find themselves faced with the task of filing returns and making payments in at least six categories of Federal, State and local taxes. This article is presented with the purpose of furnishing at least basic information on the following taxes with which most Ohio physicians are confronted.

(1) Federal Income Tax Law, including payroll withholdings on employees' salaries.

(2) Federal Social Security Tax including Old Age and Survivors' Insurance tax and the Federal and State Unemployment Insurance taxes.

(3) Ohio Personal Property Tax, including the tax on tangible property used in business and the tax on intangible personal property such as stocks, bonds, investments, cash and accounts receivable.

(4) Ohio Workmen's Compensation tax, required of those with three or more employees (optional for those with one or two).

(5) Ohio Sales and Use Tax.

(6) City Payroll Tax, applying to residents of cities which have such tax.

Information in this article is confined to those taxes on which the taxpayer or employer must file periodic returns. It does not include reviews of such taxes as those on real property, for which the taxpayer is billed directly, nor does it include discussion of many excise taxes for which the vendor of goods or services is primarily responsible; neither does it include a discussion of licenses.

The data and advice presented were obtained from authentic tax publications and from personal interviews with tax officials.

Nevertheless, physicians are advised to obtain supplemental advice and assistance in the preparation of their returns, from competent tax authorities or from staff members of the office of the District Directors of Internal Revenue or other appropriate agency. A tax expert may point the way to substantial savings as well as steer the taxpayer around embarrassing errors.

FEDERAL INCOME TAX

Taxpayers will pay 1957 Federal Income Taxes under provisions of the Revenue Code of 1954. Computation of this year's tax will be similar to that of the last two years, since there have been no changes in the law.

FORMS AND PAYMENTS

Every person under 65 years old whose gross income for the year was $600 or more, and every person 65 years old or older whose gross income was $1,200 or more, must file certain income tax returns with the District Director of Internal Revenue for his district not later than April 15, 1958.

There are three types of returns, Form 1040A, Short-Form 1040 and Long-Form 1040.

Form 1040A may be used only if the income was less than $5,000 and consisted entirely of wages reported on Withholding Statements, or such wages and not more than $100 total of other wages, interest and dividends (excluding $50 of dividends). When this form is used the Internal Revenue Service will figure the tax and send the taxpayer a bill or refund.

Short-Form 1040 is used if the income is less than $5,000 and the taxpayer must include income from sources not eligible for reporting on Form 1040A; wishes to deduct from wages certain reimbursed expenses, travel, transportation, etc.; or the taxpayer wishes to deduct credits for dividends and retirement income.

Long-Form 1040 must be used if the income was $5,000 or more, or if the taxpayer wishes to claim nonbusiness deductions that amount to more than 10 per cent of income.

INCOME-SPLITTING

Many physicians will find it to their advantage to file joint returns with their wives, whether or not the spouse has income of her own. An unmarried person who qualifies as "head of household" may claim about one-half the tax benefit afforded a married couple on a joint return.

DECLARATION OF ESTIMATED TAX

The provisions for filing declarations of estimated income taxes are principally for those persons, a substantial part of whose income is not subject to withholdings.

When filing a final return for 1957, on or before April 15, 1958, most physicians will be required to file an estimate of 1958 income.

If income from items other than wages is $100

or less, declarations are required if the gross income from wages subject to withholdings can reasonably be expected to exceed $5,000 in the case of a single person; or $10,000 in the case of a married couple, head of a household or surviving spouse.

If income other than wages subject to withholdings can reasonably be expected to exceed $100 (excluding $50 from dividends), a declaration is required if total income including wages subject to withholdings can reasonably be expected to exceed $600 multiplied by the number of exemptions that could be claimed on the taxpayer's return, plus $400.

Times to file declarations of estimated tax by individuals is April 15 (or at time final return is made), June 15, September 15 and January 15. The date for filing an income tax return in lieu of a final declaration of estimated tax is January 31. Thus, if an income tax return is not filed before February 1, the last day for filing declaration or an amended declaration is January 15.

If the estimated tax paid is 70 per cent or more of the actual tax liability, no penalty is assessed. For physicians who find it difficult to estimate their income in advance, it is suggested that they use the previous year's income as a basis and later file an amended declaration if the situation changes considerably.

PHYSICIANS IN PRIVATE PRACTICE

To summarize, most physicians in private practice must comply with the following procedures:

1. On or before January 15, 1958, make a fourth quarter return on declaration of estimated income for 1957.
2. On or before April 15, file a complete income tax return for 1957.
3. Pay the difference, if any, between the income tax paid quarterly and the amount of tax liability shown on the final return. If he has overpaid, the excess will be refunded or credited against future payments.
4. On or before April 15, file a declaration of estimated tax liability for 1958, and pay either the full amount or one-fourth of it. If he elects to pay quarterly, the remaining final dates for payment are June 15, September 15 (and January 15, 1959).

ADJUSTED GROSS INCOME

Individuals who are employed and receive a salary have little difficulty in arriving at the amount of their adjusted gross income. The total salary received plus amounts received from interest, dividends, rent, or from other sources, would in such cases constitute the gross adjusted income.

The physician in private practice has more difficulty in arriving at his adjusted gross income than the person on salary. From the amount of his cash receipts—if he reports income on the basis of cash received and disbursements, or on the amount of total charges if he uses accrual method of reporting his income—he may deduct all items of expenditure necessary in earning his income. These items are described in more detail in the following sections:

DEDUCTIBLE BUSINESS EXPENSES

Office Rental—If a physician pays rent to another person for office space, he may deduct such amount. If he rents a combined home and office, he may deduct that portion of the rent charged for the office. If he owns his own home and maintains an office in it, he cannot claim deduction for office rent. However, he is entitled to claim depreciation on that portion of the property occupied as an office, and the proportion of operating expenses chargeable to the office.

Automobile—The cost of repair and upkeep of an automobile, including gasoline and oil, used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, bus fare, etc., while on professional calls, may be deducted.

Depreciation may be deducted on an automobile used in professional business. The depreciation which should be deducted annually is determined by dividing the cost price of the machine, less salvage value, by the number of years of its usefulness. Salvage value is the estimated amount that will be realized upon sale or disposition of the automobile at the end of its useful life—the useful life varying according to the policy of the taxpayer.

If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the number of miles the car is driven for professional purposes. If a physician possesses two cars, each of which is used partly in professional business the deductible depreciation on each car should be computed on the basis of the number of miles each car is driven for professional purposes.

The physician should seek the advice of a tax expert as to whether or not application of the "declining-balance method" (explained in the instructions which accompany the tax forms) would be advantageous to him.

A loss occasioned by damage to an automobile maintained either for business or pleasure, which is not due to the willful act or negligence of the taxpayer, is deductible loss in the computation of net income, provided the taxpayer has not been reimbursed for such loss by insurance.

It is suggested that physicians be prepared to substantiate claims for deductions from gross income for professional use of automobiles in case income tax officials should call on them for written records to show the mileage traveled by

them in connection with professional practice, or to prove just what part of their automobile maintenance expense was a professional expense, and therefore deductible.

Professional Dues—Dues paid to professional associations to which, in the interest of his profession, the physician belongs, may be deducted.

Refresher Courses — The Bureau of Internal Revenue makes a distinction between expenses for advanced education and those for refresher courses (Sec. 1.162-5 of the Internal Revenue Service regulations).

The regulation provides that expenditures for education are deductible if they are for "refresher" or similar types of courses taken to maintain the skills directly and immediately required by the physician in his employment or practice. An educational course to be covered should be designed for established medical practitioners to help them keep abreast of current developments in the profession; it should be of short duration; it should not be taken on a continuing basis, and should not carry academic credit.

Cost of education designed to prepare the practitioner to enter a specialty is not deductible.

Travel Expenses—When a physician travels away from home primarily to obtain "refresher" education or to attend a medical convention for professional purposes, his expenditures for travel, meals, lodging, etc., are deductible. However, expenses for personal activities such as sight-seeing, social visiting, personal entertaining or other recreation, are not deductible. A physician who is accompanied by his wife to a medical convention may deduct the amount that the trip would have cost him alone. For example, if he and his wife have a double room, he may deduct the amount that he would have paid for a single room.

Salaries and Wages—Deductions are permitted for the salaries or wages of nurses, laboratory workers, technicians, assistants, stenographers, or other clerical workers in a physician's office so long as their duties are connected with professional work; also for wages paid maids, janitors, etc., for services rendered in connection with professional practice.

Medicine, Supplies, Etc.—Cost of medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials, chemicals and other supplies "consumed in the using" and necessary to operate the office may be deducted.

Depreciation—Depreciation may be claimed on instruments, laboratory equipment, office furniture, books, etc., of more or less permanent value, the rate of depreciation depending on the estimated useful life of the article. The "declining-balance" method of depreciation permits the taxpayer to charge off a larger proportion of the cost of equipment during its early life, under certain conditions.

If improvement to offset obsolescence and wear and tear or injury has been made and deduction for the cost claimed elsewhere in the return, claim should not be made for depreciation.

Uniforms—The Internal Revenue Service permits deduction of the cost of medical uniforms (garments, etc., necessary in practice but not suitable for street wear) as business expense.

General Office Expenses—The cost of telephone, telegrams, heat, light, water, etc., used in professional services is deductible. Physicians who keep current magazines and newspapers in their waiting rooms for the benefit of their patients, may deduct this item as a business expense. The cost of professional journals for the physician's own use is also a deductible item.

Debts—If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (i. e., all fees, either cash or account are included in income reported for tax purpose) it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician using the latter system must be careful to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

Taxes and Licenses—State and county taxes, except those assessed against local benefits of a kind tending to increase the value of the property assessed and those imposed upon the taxpayer upon his interest as shareholder of a corporation which are paid by the corporation without reimbursement from the taxpayer, are deductible. Taxes on one's own home are not to be considered as business expenses, such taxes being allowable as nonbusiness deductions only.

Fees and expenses paid for "securing the right to practice" are not deductible, such as the fee paid to secure a license from the State Medical Board. Other license fees which the physician must pay, including narcotics registration and local occupational taxes, are deductible. The cost of an automobile license, unless the car is used exclusively for business, is to be taken as a nonbusiness deduction only. The tax paid on telephone bills if the telephone is used for business only, is deductible as a business expense. This would apply to office phones. The tax paid on other telephone bills is not deductible. Federal taxes on amusements, club dues, furs and luxuries

are also not deductible for Federal income tax purposes.

Federal Old Age Benefits and Unemployment Compensation Taxes paid by employers under the Social Security Act are proper deductions in making income tax returns. Such taxes are deductible in returns for the taxable year in which they are accrued or paid, depending upon the method of accounting employed by the taxpayer. Social Security taxes withheld by an employer are not deductible by the employee in computing his tax liability.

Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

The United States Tax Court in a case decided in June, 1957, held that premiums paid by a doctor for disability insurance **are non-deductible** personal expenses, even where the policy is called a "Professional Income Policy." In the case before the court, there were no provisions in the insurance policies specifying that payments thereunder during disability were to defray or reimburse the holder for business or overhead expenses. Specific provision must be set forth in any policies of this type that the amounts will be for business or overhead expense in order to make the premiums deductible.

Sales Tax Payments—The sales tax paid in connection with purchase of items used in business become a part of the cost thereof and as such are deductible as business expenses. Other amounts expended for sales tax are nonbusiness deductions and not to be taken as business expenses.

Ohio and Federal Gasoline Taxes—There is a five cents per gallon Ohio tax on gasoline, and a three cents per gallon Federal tax. These amounts are deductible. However, if a physician has already included overall cost of gasoline as part of his business expenses, the tax is not again deductible. The Ohio 5 cents tax paid on gasoline not used in business is deductible as a nonbusiness deduction. The Federal tax is deductible only as a business expense.

Interest—Amounts paid as interest on business indebtedness may be taken as business expenses. Interest items paid on personal indebtedness are deductible only as nonbusiness deductions. Interest paid to carry tax free securities may not be deducted. The interest deduction may not exceed the portion of the total carrying charges attributable to the taxable year.

Carrying charges on installment purchases up to 6 per cent of unpaid balances are deductible where the taxpayer has carrying charge separately stated in installment sales contract.

Losses by Fire and Theft—Loss or damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair, and the cost of the repair is claimed as a deduction.

Legal Expenses—Expense incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is not deductible. The cost of contesting tax liabilities is deductible.

Entertainment — Entertainment expenses incurred as a means of enhancing a physician's practice, such as the entertainment of physicians who refer patients, and similar expenditures to attract and retain patients, are proper business expenses. The physician must be prepared to

New Tax Ruling May Clear Way For Doctor Pension Plans

A new ruling by the Internal Revenue Service may mean that doctors practicing as an association are entitled to the same tax deferment privileges as corporation employees regarding annuities.

In the now famous Kintner case, a Federal court of appeals ruled that a group of doctors, formerly associated as partners, would be entitled to tax treatment as a corporation after they banded together in an association. Until now, however, the IRS has held that it would not follow the Kintner decision, but would consider a similar association as a partnership, and partners can't be employees under a pension plan.

Now IRS is reversing itself; it will not deny the favored tax status to an association of doctors simply because indications are the association was formed to obtain pension plan benefits for members of the association.

If IRS maintains this policy, the effect will be to allow doctors forming an association (in line with IRS criteria yet to be established) to enjoy approximately the same annuity advantages they would under the Jenkins-Keogh and similar bills now pending in Congress. The sponsors would have to meet two tests: the association would have to qualify for the federal tax benefits, while at the same time avoiding the charge, under state law, of engaging in the corporate practice of medicine.

prove that such expenditures have a direct income-producing relationship to his practice; otherwise, they will be disallowed. A detailed record should be kept of each item of business entertainment expense, together with dates, amounts, names of persons entertained, the nature of the expense, and recipients of payment. Wherever possible, such expenses should be made on a charge account and paid by check so that a permanent record may be retained. The physician must be able to show from his other records the business benefit he derives from the persons he entertains. Extensive business entertainment or the expenditure of an unusually large proportion of income for this purpose makes it difficult to establish that the entire amount of these expenditures has a direct income-producing relationship to the physician's practice.

Reliable sources report that orders have gone from Washington telling all field offices to "scrutinize expense accounts closely."

Tax authorities have strongly suggested that such expenses as social club dues be prorated partly as business expenses if that is the case, and partly as personal expenses.

The same is true of travel expenses to out-of-town medical meetings. If the physician goes primarily to attend a professional meeting, he may deduct all of his expenses. If he attends a professional meeting, but extends his stay, he should prorate expenses.

EXEMPTIONS AND ALLOWANCES

An exemption of $600 may be claimed by the taxpayer for himself. He may also claim an exemption of $600 for each dependent of close relationship, or for certain other dependents living in his household. To claim an exemption for a dependent, the taxpayer must have furnished over half of the actual amount used for the dependent's support in the taxable year. Scholarships do not count as income to the child in determining the extent of parental support.

Exemption also is contingent upon the dependent, other than a child, having a net income of less than $600 for the year. A child may earn $600 or more and still qualify as a dependent if he is under 19 or a full-time student for five months during the year, or taking on-the-farm training, provided the taxpayer contributes more than half of his support.

An additional personal exemption of $600 may be claimed by the taxpayer if he is over 65, another if he is blind; another if his spouse is blind; and still another if the spouse has reached the age of 65. (These provisions do not apply to dependents other than spouse.)

NONBUSINESS DEDUCTIONS

Regardless of whether or not the taxpayer claims business expenses, he may claim the following deductions if eligible to do so, **providing that there is not a duplication of deductions under the two categories.**

Contributions, Gifts, etc.—The individual taxpayer may deduct contributions up to 30 per cent of adjusted gross income, if the last 10 per cent is given to a church, an association of churches, an educational institution or a hospital. The ceiling remains at 20 per cent for contributions to other charitable organizations, no substantial part of the activities of which are carrying on propaganda or otherwise attempting to influence legislation.

Medical and Dental Expenses—The taxpayer may deduct medical and dental expenses which exceed 3 per cent of the adjusted gross income. However, in figuring these expenses, the amount paid for medicine and drugs may be taken into account only to the extent it exceeds 1 per cent of the adjusted gross income.

The deduction may not exceed $2,500 multiplied by the number of exemptions other than the exemptions for age and blindness. In addition there are maximum limitations as follows: (a) $5,000 if the taxpayer is single and not a head of household or a qualifying surviving widow or widower; (b) $5,000 if the taxpayer is married but files a separate return; or (c) $10,000 if the taxpayer files a joint return, or is a head of household or a qualifying surviving widow or widower.

If the taxpayer or his wife is 65 or over, the maximum limitations are the same as in the foregoing paragraph. However, amounts deductible for medical and dental expenses are not restricted to the excess over 3 per cent of adjusted gross income. In effect, the 3 per cent rule may be disregarded. But the amounts spent for medicine and drugs are still limited to the excess of 1 per cent of income, and amounts spent for dependents' medical expenses are deductible only to the extent they exceed 3 per cent of adjusted gross income.

Medical expenses paid by an estate within one year after death are considered paid by the decedent.

The term "medical care" is broadly defined to include "amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurances)."

In regard to payment of premiums on accident and health insurance, the Internal Revenue Service has ruled that premiums may be deducted for insurance that provides for indemnity for the cost of medical care and specific injury, but may not be deducted for insurance which indemnifies the holder solely for the loss of earnings.

In order to obtain this credit for medical and dental expenses, the taxpayer is required to list the name and address of the person to whom the payment is made, the approximate date of actual payment and amount. It should be noted that this

will furnish the Internal Revenue Service with data which can be used in checking returns filed by physicians and dentists—another reason why they should keep accurate records and compile their returns carefully.

Interest—The taxpayer may deduct interest on a personal note to a bank or individual, a mortgage on his home, a life insurance loan if the interest is paid in cash, or interest on delinquent taxes.

Taxes—Deduction may be made for taxes paid on personal property or real estate, for city income taxes, retail sales taxes, auto license fees, state gasoline taxes.

Casualty Losses and Thefts—The taxpayer may deduct losses due to destruction of property by fire, stolen property or cash, and storm damage, if not claimed as a business deduction and not covered by insurance.

OPTIONAL STANDARD DEDUCTION

The optional standard deduction permitted in lieu of listing amounts paid for contributions, interest, taxes, and other nonbusiness deductions is 10 per cent of the adjusted gross income, but not in excess of $1,000, or $500 in the case of a married person filing a separate return.

PARTNERSHIPS

The partnership itself is not subject to income tax, but is required to file an information return. The tax liability falls upon the individual partners. Partnerships may be simple agreements by which two or more physicians share expenses and prorate income. On the other hand, they may be elaborate entities. Since there are many special regulations pertaining to partnerships, partners would do well to seek expert advice.

RETIREMENT INCOME

Retirement income, including pensions, annuities, interest, rents, dividends, etc., are subject to special treatment under the income tax laws.

DISTRICT OFFICES AND DISTRICTS

Income tax payments and returns must be made at or mailed to the office of the District Director of Internal Revenue for the district in which the taxpayer has his legal residence. There are four internal revenue districts in Ohio. The counties comprising each district follow:

For the Columbus District (Ohio 11th) Director of Internal Revenue, 110 W. Long St., Columbus; comprising the following counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

For the Cleveland District (Ohio 18th) Director of Internal Revenue, 626 Huron Rd., Cleveland; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Monroe, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

For the Cincinnati District (Ohio 1st) Director of Internal Revenue, Post Office Building, Cincinnati; comprising the following counties:

Brown, Butler, Clark, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble and Warren.

For the Toledo District (Ohio 10th) Director of Internal Revenue, Toledo; comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Drake, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot.

INCOME TAX WITHHOLDINGS

Every employer who pays wages to **one or more** employees, where an employer-employee relationship exists, must withhold from such wages and pay over to the Federal Government periodically an amount prescribed by law.

The amount to be deducted from each pay check may be determined by referring to the *Employer's Tax Guide Circular E* after having the employee fill out Form W-4 to determine the number of exemptions he claims. The handbook is supplied by the District Office of the Director of Internal Revenue.

The amount deducted is paid to the District Office of the Director of Internal Revenue together with report on Form 941, quarterly during the month immediately following the quarter for which deductions are made. (Social Security taxes are reported on this same form.)

The employer is required to give each employee from whose wages he has withheld income tax during the year a statement in duplicate showing the amount of tax withheld and wages paid for that year. Forms W-2 in quadruplicate are supplied for this purpose. The original copy of Form W-2 is to be filed with the Employer's Quarterly Federal Tax Return, Form 941, for the last quarter. The second and third copies are furnished the employee and the fourth copy retained by the employer for his records. Statements must be furnished employees and reports made to the government between January 1 and January 31, for the previous year.

DEPOSIT OF WITHHOLDINGS

An employer who withholds as much as $100 per month for the purposes of income tax liability and F. I. C. A. liability (employer's and employee's shares) shall take these funds with

Form 450 to a bank and deposit them. The bank transmits this form to the Federal Reserve Bank in Cleveland for validation, after which it is returned directly to the employer. The depositary receipt, Form 450, is then eligible for use.

REPORT OF FUNDS PAID

As in previous years, payments in excess of $600 made during the year for interest, rents, or commissions, not subject to withholdings and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 15 of the following year to the Director of Internal Revenue, Processing Division, Kansas City, Mo.

SOCIAL SECURITY TAXES

The Federal Social Security Act embodies laws pertaining to Old Age and Survivors' Insurance and Unemployment Insurance. Because the procedures for paying these taxes are different, they are discussed here under separate headings.

A person 65 years old or older who is receiving Social Security benefits may now earn up to $1,200 a year without losing his benefit. For any excess earnings over $1,200 he may lose one month's benefits for each $80 or fraction thereof. A person 72 or older may earn any amount and continue to draw benefits.

Not covered for social security purposes are services performed by an individual in the employ of his son, daughter, or spouse, and services performed by a child under 21 in the employ of his father or mother.

Under provisions for coverage of self-employed workers, physicians are specifically excluded.

Domestic workers in private homes who receive wages of at least $50 in a quarter are covered. In other words, if a taxpayer has a cleaning woman, or other domestic worker, only one day a week, she must be covered if she earns $50 or more in a quarter (approximately $3.85 per week). Domestic workers in farm homes come under the same provisions as farm workers.

A farm worker who earns $150 in cash wages during the year must be covered. However, farm workers who perform agricultural services for an employer for 20 or more days during a calendar year for cash at a rate based on some unit of time must be covered regardless of the rate.

Only cash is considered in wages paid to domestic or farm workers, not wages in kind.

OLD AGE AND SURVIVORS' INSURANCE TAX

The Old Age and Survivors' Insurance Tax is payable by every employer who employs **one or more persons** in his office or home.

The employer deducts 2¼ per cent of the employee's wages at each pay period and contributes a like amount himself. Payments are made on the first $4,200 of annual salary only.

The tax return and informational return, combined in one report, is to be filed quarterly. The tax must be paid and the return filed on or before April 30, for the months of January, February and March of that year, in the office of the District Director of Internal Revenue, and quarterly thereafter, payable during the month after the quarter ends.

The employer who hires household help only should file on Form 942, which is in the form of an envelope for convenient mailing. The employer who reports his office workers on Form 941 may add his domestic workers to this same form.

Farm workers must be reported on Form 943.

UNEMPLOYMENT TAX

Physicians or other employers who have **three or more** employees, including other physicians, nurses, receptionists, technicians, office workers, etc., are subject to the Ohio Unemployment Compensation Tax. Those who have **four or more** are liable also for the Federal Unemployment Insurance Tax.

OHIO UNEMPLOYMENT COMPENSATION TAX

In general, employment of **three or more persons** in any one day including part-time workers renders the employer liable for this tax. A physician who is in doubt as to his liability, should request clarification from the Bureau of Unemployment Compensation, 427 Cleveland Ave., Columbus 16.

Reports are made during the month following each calendar quarter on forms supplied by the Bureau. The tax rate is established for each employer annually. A copy of the calculations made by the Bureau is mailed before the first of the year to each employer. This shows how the rate for the employer for that year was calculated. This rate starts at 2.7 per cent and may be reduced to as low as one-tenth of one per cent. Only the first $3,000 paid by any employer to any one individual within a calendar year is taxable.

Liable employers should furnish a form BUC-400 to each employee upon separation. These forms may be obtained from the local employment office. If the employee files a claim for benefits, the Bureau will request separation and wage information from the employer. It is imperative that this form requesting separation information be returned to the Bureau within seven days of its receipt.

FEDERAL UNEMPLOYMENT TAX

The Federal Unemployment Insurance Tax applies to employers who have had **four or more persons** on their payrolls on 20 or more days in the calendar year, each of the 20 days being in different calendar weeks. It is payable to the District Director of Internal Revenue by January 31 for the previous year. The gross tax is three per cent on all individual wages up to $3,000 and is paid exclusively by the employer—the employee making no contribution. A credit not to exceed 90 per cent of this tax is allowed on all payrolls

which were reported to the state unemployment compensation agency (see under Ohio Unemployment Compensation Tax) and the state tax paid by January 31. If an employer has paid his state unemployment tax in full, the Federal tax is reduced to three-tenths of one per cent.

OHIO WORKMEN'S COMPENSATION

The purpose of the Bureau of Workmen's Compensation is to maintain a Workmen's Compensation Insurance Fund from which to pay compensation to workmen for injury or occupational disease and compensation to dependents for death occasioned in the course of or arising out of employment.

Every employer in the state employing **three or more** employees regularly in the same business is required to furnish the Bureau of Workmen's Compensation with specified information about employees he has had during the previous year, and to contribute to the State Insurance and Occupational Disease Fund in an amount based on the payroll and at a premium rate based on the class of risk. (The employer under certain circumstances may elect under bond to comply with the provisions of the law by self-insuring the risk.)

Employers of **less than three** employees may voluntarily subscribe to and obtain insurance in the Fund.

Insurance accounts are adjusted and reports made for the first half and second half of the calendar year. Reports are due with premiums attached by September 1 for the first half of the year, and by March 1 for the second half of the year. Another requirement is an advance permanent deposit based on eight months estimated payroll for the periods January 1 - August 31 and July 1 - February 28, respectively.

The Bureau of Workmen's Compensation in recent years has undergone a decentralization program. The Bureau now comprises 16 regional offices in addition to the central office in Columbus.

OHIO PERSONAL PROPERTY TAX

Returns under the Ohio Personal Property Tax Law must be made between February 15 and April 29 annually. One-half of the amount of the tax is paid when the return is filed, and the other half is due September 20.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies (including medicines), etc. Such tangible property should be listed at its book value. A depreciation of 10 per cent annually from cost will be allowed until such equipment reaches a value of 30 per cent. It should stop at that figure for a year. Then such office equipment may be reduced 5 per cent each year until it reaches a minimum value of 20 per cent, which value should be kept as a utility value.

When a physician opens his practice (or a person starts in business) during the calendar year, he is required by law to list all his taxable property, except inventory, as of the date he engaged in practice. In listing inventory he should list the probable average value (at any one time) intended to be used between the time he engages in practice and the end of the year. The valuation of all taxable property including average inventory to be returned for taxation is determined by multiplying the value by the number of months the taxpayer has been in practice and dividing by 12.

Forms 937 and 902, obtained from the Ohio Department of Taxation, must be filed with the Personal Property Tax return to obtain a lesser value than 30 per cent.

Returns should be filed in duplicate. The so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

One of the complicated provisions of the tax law is that involving the listing of credits which are taxable at 3 mills on the dollar, and which involves the computation of accounts receivable.

Accounts receivable are to be listed in accordance with Section 5711.18 of the Revised Code part of which reads, "Claim for any deduction from net book value of accounts receivable or depreciated book value of personal property must be made in writing by the taxpayer at the time of making return," on supplementary tax form 902.

All taxable personal property and credits used in business shall be listed as of the close of business of the last day of December, annually.

As defined in Section 5701.07 R.C., credits "mean the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments."

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

To arrive at a fair estimate of his current accounts receivable, the physician is advised to note after each account what he considers its value. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise it should be listed at a percentage of its true value, or "no value" if that is the case. The total of these estimates is the amount to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts. It also allows him to depreciate the actual value of accounts returned in the tax

year, but which have decreased in actual value during that year.

Some physicians misunderstand the provision requiring the listing of accounts receivable for taxation. Some think that physicians are the only ones who have to do so and that the law is discriminatory. That is not true.

Every person who possesses intangible assets, *such as accounts receivable*, or any business or professional man who does business on credit basis and keeps books, must return his accounts receivable for taxation.

Such person must keep in mind that he can estimate depreciation on his accounts receivable and that he can use *accounts payable* as an offset against accounts receivable, paying the tax on the difference.

Obviously, the percentage discount used by a physician in depreciating the value of his accounts receivable will depend to a large extent on the doctor's collection experience and on the economic status of the majority of his patients. In other words the physician who has difficulty in collecting bills or whose practice serves a large number of persons in the low-income brackets or who are poor credit risks, should use a higher depreciation formula than the physician who does not have these factors to contend with.

OHIO SALES AND USE TAX

Section 5739.02 Revised Code levies an excise on each retail sale made in Ohio of tangible personal property.

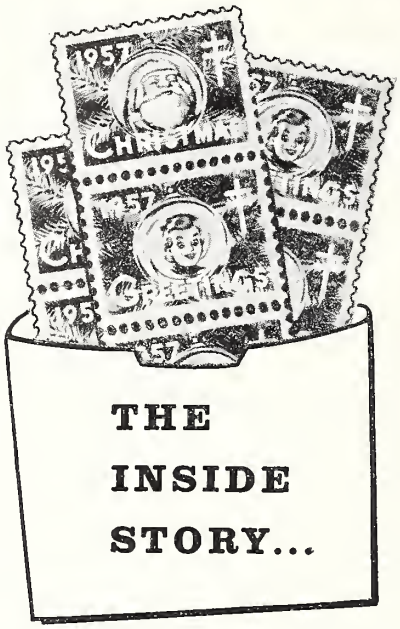
The Ohio Use Tax Law, passed in 1936, supplements the Retail Sales Tax Law and imposes a tax on the same basis as the sales tax on purchases made outside the State. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Ohio Department of Taxation to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Department.

However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Tax Department, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by next April 15 for purchases, during the period January 1 to March 31, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014, "The Quarterly Consumers Return."

Section 5739.01, Revised Code, contains this provision: "Physicians, dentists, hospitals, and blood banks operated by non-profit institutions are consumers of all tangible personal property purchased by them in connection with the practice of medicine, dentistry, or rendering hospital or blood bank service. They shall not be required by any provision of Sections 5739.01 to 5739.31, inclusive, and 5741.01 to 5741.22, inclusive, of the Revised Code, to collect sales or use tax on property transferred by them to patients in connection with the rendition of professional services provided that if physicians, dentists, and hospitals are engaged in selling to consumers tangible personal property as received from others, such as eye glasses, mouth washes, dentifrices, or similar articles, the tax shall apply to such sales."

CITY PAYROLL TAX

Several cities in Ohio have enacted laws imposing income tax on wage earners and making the employer responsible for deducting the tax from wages paid employees. For example, Columbus has a law which requires the employer to deduct a percentage of the employee's wages and make returns to the city auditor quarterly. A physician who moves into a new location should inquire as to what tax laws may be in force locally.



Your Christmas Seal letter asks you to give to the fight against tuberculosis.

Christmas Seal funds have helped cut the TB death rate 95% ... yet **TB still kills more people than all other infectious diseases combined.**

So use Christmas Seals from now 'til Christmas ... and remember to answer the letter, please.

Buy and use Christmas Seals

Workmen's Compensation . . .

State Bureau Paid Out More Than $8-Million During Year on Medical Services for Workers; Breakdown Shows Other Expenditures of Agency

THE Ohio Bureau of Workmen's Compensation during the calendar year 1956 paid out $8,117,236.42 for medical services to injured Ohio workers, according to information provided by the Actuarial Section of the Bureau. That amount excluded a small sum for dental services.

Other 1956 expenditures, exclusive of compensation payments, included the following: $9,641,-846.76 for hospital care and nursing; $246,935.16 for funeral expenses, and $81,742.43 for miscellaneous costs. With disbursements for medical expenses added, the total is $18,087,760.77.

These amounts include payments covering treatment of injured private and public employees, as well as similar costs for occupational disease claims.

Comparative figures for 1955 were as follows: $7,473,546.61 for medical services; $8,441,211.63 for hospital care and nursing; $301,701.94 for funeral expenses, and $395,264.91 for miscellaneous costs; a total of $16,611,725.09.

The number of claims filed during 1956 was 342,801, or 2.2 per cent more than in 1955.

"Medical-only" claims, involving payment for physicians' services, but with no compensation for the claimant for loss of time, numbered 273,566 for 1956, or 80 per cent of all claims filed. The average amount paid out for "medical-only" claims increased from $17.03 in 1955 to $17.80 in 1956.

Table 1 is a financial statement of the Ohio Insurance Fund.

Table 2 gives the 1956 awards that have been made active claims according to the year of injury and having injury dates which in some cases reach back to the beginning of the fund in 1912.

TABLE 1

OHIO STATE INSURANCE FUND

(Workmen's Compensation)

STATEMENT OF FINANCIAL CONDITION

As of December 31, 1956

ASSETS

	Private	Public	P.W.R.E.	Safety & Hygiene	Total
Cash	$ 5,238,770.74	$ 236,724.86	$ 30,602.92	$ 60,323.15	$ 5,566,421.67
Bonds	226,205,953.05	9,908,055.85	911,637.10	2,878,854.00	239,904,500.00
Premiums in Course of Collection	47,957,429.53	8,660,541.65	26,089.00		56,644,060.18
Accrued Interest	484,888.02	21,238.60	1,954.16	6.171.02	514,251.80
Administrative Cost Assessment	516,166.44				516,166.44
Total Assets	$280,403,207.78	$18,826,560.96	$970 283.18	$2,945,348.17	$303,145,400.09

LIABILITIES

Reserve for Medical and Compensation	$226,423,362.10	$18,816,730.41	$120,865.00		$245,360,957.51
Advance Premium Deposits	39,294,332.11				39,294,332.11
Administrative Cost Assessment		2,251.22			2,251.22
Fund				2,945,348.17	2,945,348.17
Reserve for Contingencies and Surplus	14,685,513.57	7,579.33	849,418.18		15,542,511.08
Total Liabilities	$280,403,207.78	$18,826,560.96	$970,283.18	$2,945,348.17	$303,145,400.09

TABLE 2—PRIVATE FUND

Medical, Hospital, Etc., Awards Distributed to Year of Injury Occurrence

(Accident and Occupational Disease Combined)

Year of Accident or Disease	Awarded	1956 Per Cent	1955 Per Cent
1956	$7,298,182	41	43
1955	5,110,536	29	25
1954	1,214,181	7	9
1953	825,167	5	5
1952	629,188	4	3
1951	508,930	3	3
1950	335,302	2	2
1949	275,081	2	1
1948	188,997	1	1
1947	123,537	1	1
1912-1946	1,139,919	5	7
Total	$17,649,020	100	100

New Code of Ethics for Hospitals . . .

Revision Supplants Former Code; Principles of Conduct for Hospital Administrators Also Formulated by Committee of Two National Groups

A NEW revised Code of Ethics for hospitals and hospital administrators has been released by the American Hospital Association and the American College of Hospital Administrators. It supplants a Code produced and adopted in 1939 by the two organizations.

The revision, prepared by a joint committee representing both groups, consists of a ten-point statement on hospital ethics and a ten-point statement of principles of conduct for hospital administrators. Both statements were derived from a statement of Administrative Principles for Hospitals, Hospital Administrators and Hospital Personnel formulated initially by the joint committee and containing both ethical principles and operational procedures. Text of the codes follow:

HOSPITAL CODE OF ETHICS

1. Recognizing that the care of the sick is their first responsibility and a sacred trust, hospitals must at all times strive to provide the best possible care and treatment to all in need of hospitalization.

2. Hospitals, cognizant of their unique role of safeguarding the nation's health, should seek through compassionate and scientific care and health education to extend life, alleviate suffering, and improve the general health of the communities they serve.

3. Hospitals should maintain and promote harmonious relationships within the organization to insure the proper environment for the considerate and successful care and treatment of patients.

4. Hospitals should appreciate and respect individual religious practices and customs of the patient.

5. Hospitals, to the extent possible, should conduct educational projects, stimulate research, and encourage preventive health practices in the community.

6. Hospitals should cooperate with other hospitals, health and welfare agencies, governmental and private, and other recognized organizations interested in promoting the health of the nation.

7. Hospitals in reporting their work to the public should give a factual and objective interpretation of accomplishments and objectives without disparaging the work of other hospitals or related organizations.

8. Hospitals should actively support and encourage every effective method which will ease the financial burdens of illness.

9. Hospitals should be fair, honest, and impartial in all their business relationships.

10. Hospitals should be progressive in policies, personnel practices, and efforts to maintain up-to-date equipment, methods, and standards of performance.

CODE FOR ADMINISTRATORS

The hospital administrator's life is dedicated to the highest possible level of performance in the competent and humane hospital care of the sick, in health education in all its many phases, and in research conducted in the interest of hospitals and their patients. In pursuing these objectives the hospital administrator should be guided by the following principles.

1. He will not use his position or influence for selfish personal advantage or gain and will not disparage the work of his colleagues.

2. As the official representative of the hospital's governing body and often the hospital's spokesman in the community, his conduct will at all times be dignified and exemplary. His professional performance will be objective and fair, with the patient's best interest as the ultimate consideration.

3. In his relationships with personnel and staff he will be impartial, tolerant, fair, and interested in all reasonable means of promoting personnel morale and welfare, consistent with the hospital's best interests and ability to provide them.

4. The administrator will encourage, assist, and teach others the principles and practice of hospital administration to the end that future hospital administrators may be more adequately prepared.

5. The administrator will encourage and participate, to the extent possible, in a broad educational program to assure the health workers necessary to the hospital field.

6. He will contribute his interest, support, and leadership toward the general improvement of the community, with especial emphasis on health education and related causes. In so doing he will attempt to avoid involving his hospital in partisan political issues.

7. In his relationships with the Medical Staff of the hospital he will support that which is constructive, sound, and in the interests of good hospital professional practice; he will resist and oppose that which is, in his judgment, harmful, destructive, or unwise.

8. The administrator will seek constantly to improve his professional knowledge and skill and will accept counsel and guidance, particularly in

fields and subjects with which he is not entirely familiar.

9. Recognizing that his is a position of public trust, he will, within the limitations imposed by good judgment, legal considerations, and his hospital charter respect the rights, privileges, and beliefs of others regardless of race, color, or creed. He will keep confidential whatever he may learn respecting the private affairs or character of patients and their families, physicians, and others with whom he is associated in the hospital. When his administrative duties bring him into conflict with any segment of society or belief, he will deal with the situation with the greatest consideration, courtesy, and respect for the individual that is possible, without ridicule or animosity.

10. He will exemplify the Golden Rule in thinking, action, and conduct.

Opinions Issued by Attorney General

Opinion 1017—1. Health districts, both city and general, have the power to require the registration and licensing of water well drillers and pump installers.

2. Health districts that require registration and the licensing of water well drillers and pump installers may charge the applicant for such registration and licensing, but there must be a reasonable correlation between the actual cost of administering the registration and licensing program and the fee charged.

3. A health district having established standards for registering and issuing licenses to water well drillers and pump installers, may grant such license to a person who has been registered and licensed by another board, but only after ascertaining that the standards adopted by such other board are at least equal to its own.

Opinion 1029—A nurse who does not renew the certificate of registration, as provided for in Section 4723.24, Revised Code, cannot use the title "registered nurse" or the letters "R. N." during the period of time the certificate of registration has lapsed.

Opinion 1177—1. The board of trustees of a county tuberculosis hospital of more than 50 beds, may not authorize the medical superintendent employed on a full time basis, as provided in Section 339.30, Revised Code, or a qualified medical assistant so employed, to collect and personally retain fees in addition to his regular salary when such fees are for medical and surgical treatment rendered to "in" or "out" patients of such hospital.

2. Under the provisions of Section 339.30, Revised Code, the board of directors of a county tuberculosis hospital, alone, are authorized to make charges of patients for the services of the hospital, and as provided in Section 339.20, Revised Code, such hospital services include medical and surgical treatment.

You and Your Public . . .

Good public relations start in the doctor's office, so they say.

Therefore, the doctor should know what his patients think about while they wait for him in the waiting room. What are their moods? Do they talk about questions which they fail to take up with the physician?

One physician decided to find out something about the people in a doctor's waiting room. Dr. Willis E. Hammond, president of the Madison County (N. Y.) Medical Society, made an engagement with his personal physician. In his President's Page of his county medical society bulletin, Dr. Hammond related his experience as follows:

"I would like to sound a call, doctor, for a review of our most intimate moments with our patients.

"Not long ago I had the opportunity to sit in the waiting room of my personal physician. I had requested that professional courtesy not be employed and that I be allowed to await my turn. It was a revelation. From the conversation, comparison of illnesses and comment of the waiting patients I received an enlightening education. Patients have a medical outlook about themselves which is made up of factors that are seemingly trivial to the doctor but crucial to the patient.

"We have heard of the physician who overlooks these factors and goes into a long dissertation on some complicated syndrome or evaluation of events which he himself required many years to understand. To the patient this is meaningless. The result is frustration at a moment when there should be complete understanding. It is so simple to overlook the obvious.

"We are rushed in our practice today. We have seen the same illnesses and complaints over and over again. We forget. Then, to the patient, we appear rough, abrupt and uninterested. Perhaps it is time for us all, doctor, to evaluate our professional conduct in an effort to establish physician-patient relationships based on simplicity, honesty and understanding."

New AMA Directory Scheduled For Mid-Summer 1958

The 1958 Edition (20th Edition) of the *American Medical Directory* will soon be going to press and will be ready for mailing in the summer of 1958. AMA is offering a pre-publication price—just $30.00 for the U. S. A. and Possessions, and $33.00 outside the U. S. A. and Possessions. After January 1, 1958, the price on all orders will be increased to $35.00 for U. S. A. and $38.00 outside the U. S. A. and Possessions.

What To Tell the Patient . . .

Is One of the Tough Questions the Physician Must Answer; Pros And Cons Discussed by Panel in N. Y. Reported in Ciba Magazine

"SHOULD I tell the patient the truth?" Supplying the answer for that question is not easy for most physicians. How do most physicians meet this question? Some interesting material on this subject appeared in a recent issue of *Ciba Medical News*.

Here are excerpts from the article which carried the heading, "Nothing But the Truth?"

* * *

THE QUESTION

The doctor in Mark Twain's short story "Was It Heaven? Or Hell?" snaps, "Told a lie, did she? God bless my soul, I tell a million a day! And so does every doctor."

True or not in Mark Twain's day, medicine has changed so much that few doctors today have to wrestle with the truth quite that often.

Yet no conscientious practitioner can say he has never had to pause over the question, "Should I tell the patient the truth?" Or "Isn't a little deception sometimes better therapy?"

Most doctors in practice are eager to know how their colleagues answer the question, "Should patients be told the truth about serious illness?" This was the subject of a recent panel discussion at New York Hospital-Cornell Medical Center. Dr. Claude E. Forkner, professor of clinical medicine at Cornell University Medical College and editor of the series "Practitioners' Conferences," was moderator.

GENERAL RULES ARE ELUSIVE

Although by no means in complete agreement, the panelists were able to establish a fairly conclusive pattern on at least four points.

1. *There is no hard and fast rule.* Said Dr. Arthur M. Sutherland, psychiatrist and assistant professor of clinical medicine at Cornell: "The question cannot be answered fully because it presumes a standard disease, a standard patient, a standard physician, none of which exists. It is very much like the question, 'Have you stopped beating your wife?'"

2. *In some illnesses, the truth won't help.* Said Dr. Carl Binger, consultant in psychiatry, Massachusetts General Hospital: "You will not help a schizophrenic patient face the fact that he has a serious mental illness by telling him, 'You are a schizophrenic,' even if it's the truth."

3. *The law takes a limited view of "medical truth."* Said George A. Brownell, New York attorney: "There is no general legal principle that a doctor, no matter how high his motives, may tell a patient an untruth with complete immunity under all circumstances."

BETTER BE RIGHT

But the doctor who tells a patient the "truth" had better be right. Mr. Brownell recalled a Massachusetts case involving a young man engaged to be married, "The doctor who examined him told him he had a venereal disease, but, as it turned out, he didn't. The engagement was broken off. The doctor was sued and held liable."

Also, from the lawyer's point of view, Mr. Brownell said, there are sometimes practical questions to be considered in determining what facts to give the man with a terminal illness. To take just one example, he explained, "wills written before the recent marital deduction provisions in our Federal tax laws sometimes involve the payment of a large percentage of the estate in taxes which could be avoided if these wills were rewritten."

HOW IS IMPORTANT

4. *The most important factor is not so much what one tells the patient as how one does it.* Clearly, confidence in the physician is basic in the patient's adjustment to serious disease.

On these points the panelists were in agreement. But they disagreed sharply on how—and how much—to tell the patient.

Dr. Forkner declared: "In the many years that I have been in practice, seeing several thousands of patients and telling them the truth, I have never yet had one blow his brains out, nor have I ever had one get angry and blame me.

"The more you tell the patient, the less he seeks to be an authority. He only seeks to be an authority and to read all the books if you do not tell him, or if he thinks you are not doing all that can be done for him."

Dr. Sutherland did not agree. "Patients do not want to be assaulted with the information, especially on the first visit. One patient said to me, 'Doctor, don't tell me anything. I do not want to know what disease I have, or what you are going to do; just don't tell me.'

"If you know the patient well enough, he will come to you with questions and let you know how much he wants to know. I think the principle is very much like teaching a child the facts of life. One tells the child what it needs to know

at the time. You do not start instructions with tales of rape."

AND THE WHOLE TRUTH?

Dr. Binger: "Shall we tell the patient all the facts, or only some of the facts?"

Dr. Forkner: "You can give the patient enough information so that he can get his affairs in order, so that he can do the things that he wants to do, and yet is not deceived by what you have told him."

Dr. Sutherland: "If you have spent an hour to three hours talking to the patient to establish a good relationship which indicates to him that you will do as much as possible for him—when you have established that, the kind of information is less important. In some instances, however, I do not believe the whole truth can ever be tolerated. I would not like to be given a report and be told, 'We have seen your biopsy specimen—have you made your will?'"

Is this the truth? Or only part of the truth? Is it the truth to say that tomorrow's research may well make a liar out of today's most forthright doctor? Perhaps. But it is also true that the basic question of what to tell the patient can only be answered by the attending physician. Yet answer it he must.

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

August 27—Gerald P. Davey, Cuyahoga Falls, Georgetown University.

October 8—Robert C. Anderson, Columbus, Indiana Univ.; Arthur Barnes, Cleveland, Boston Univ.; Franz J. Berlacher, Toledo, Univ. of Chicago; Byron M. Bloor, Cleveland, Duke University;

Vernon L. James, Jr., Columbus, Univ. of North Carolina; John W. C. Johnson, Cleveland, Univ. of Virginia; Thomas L. Jones, Cincinnati, Univ. of Maryland; Louis von Kibedi-Varga, Cambridge, Univ. of Szeged, Hungary; Rachel L. B. W. McDougal, Cleveland, Univ. of Pennsylvania; George C. McElfatrick, Cambridge, Univ. of Maryland;

Joseph M. O'Connor, Akron, New York Medical College; Anne West Robinson, Canton, Univ. of Minnesota; Arnold G. Schwyzer, Dayton, Johns Hopkins Univ.; Charles G. Sickles, Columbus, Columbia Univ.; George R. Swan, Cambridge, Univ. of Buffalo;

Richard H. Tapogna, Springfield, Stritch School of Med. of Loyola Univ.; Walter H. Waskow, Cleveland, Hahnemann Medical College; Israel Weisberg, Cleveland, New York University.

New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since October 1, 1957. The list shows the County in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ADAMS COUNTY
Alfonsas Pakalnis, Peebles

ALLEN COUNTY
Lee E. Bartholomew, Lima
John P. Kemph, Elida
Thomas R. Leech, Lima

CUYAHOGA COUNTY
Nicholas Deychakiwsky, Cleveland
Seymour Friedman, Cleveland
H. Dean Hudnutt, Cleveland
David V. Morrison, Cleveland
Robert E. L. Rochelle, Cleveland
Carter C. T. Wang, Cleveland

FRANKLIN COUNTY
Alfred L. Joseph, Columbus

GUERNSEY COUNTY
John O. Odabashian, Cambridge
Thomas D. Swan, Cambridge

HAMILTON COUNTY
George E. Brown, Cincinnati
Donald W. Hillman, Cincinnati
Frank Lee Jett, Cincinnati
Jack R. Kirschner, Cincinnati
Lester W. Martin, Cincinnati
Fernando L. Mendez, Cincinnati
Harold Perry, Cincinnati
Jack H. Rubenstein, Cincinnati
Edward M. Schneider, Drift, Kentucky
Edward S. Strasser, Cincinnati

LAKE COUNTY
Laima Adamsons, Willoughby
William E. Fletcher, Painesville

LORAIN COUNTY
William Wladecki, Elyria
Ward V. B. Young, Jr., Elyria

LUCAS COUNTY
Virginia Hendricks, Toledo
Richard Kappus, Toledo
Joseph A. McCarthy, Toledo
John F. Miller, Toledo

SUMMIT COUNTY
Leroy G. Dalheim, Akron

Council Named to Review Financial Status of OASI

A 12-man advisory council has been named to review the financial position of the Social Security system and report back to Secretary Folsom. The council, provided for by the 1956 Social Security amendments, will review the status of the OASI trust fund and the new disability insurance trust fund in relation to the programs' long-term obligations. Scheduled payroll tax increases for 1965, 1970 and 1975 also will be studied. Mr. Folsom said the council could look into the cost of any new program (such as hospitalization at age 65), although studies of possible changes were not mentioned in outlining the group's duties.

Asked the position of the Department of Health, Education, and Welfare on the Forand bill for free hospitalization of the aged under Social Security, the secretary said there was no position, "but in a general way we are concerned with not getting payroll taxes to too high a level. Now payroll taxes are scheduled to reach 4¼ per cent for both employer and employee and 6-3/8 per cent for the self-employed by 1975. Also, these taxes are on gross earnings, with no deductions (as for income taxes)."

Labor Officials Advised . . .

California Medical Association Sets Forth Policy for Relationship With Union Medical and Welfare Plans Under Four Basic Principles

IN a recent issue of the *Newsletter* of the California Medical Association, there appeared the text of a statement approved by the Council of that association, setting forth policies for the relationship between the association and labor health and welfare plans.

Specifically, the statement was a part of a letter sent to the trustees of the Union Health and Welfare Plans for the Construction Industry of Northern California.

Because of the current interest and importance of the subject, *The Journal* is republishing the text of the letter which CMA sent to the labor officials. It read as follows:

TEXT OF LETTER

"As evidence of our willingness to cooperate in the solution of problems revolving around the delivery of medical care, the Executive Committee of the California Medical Association met with you, the Trustees of Health & Welfare Plans for the Construction Industry of Northern California, on April 10 of this year.

"As an outgrowth of that meeting we are, herewith, presenting the C. M. A.'s views: our attitude based upon the fundamental principles that the patients' interest must remain uppermost in the minds of the discussants on both sides of the table at all times.

"The California Medical Association is a voluntary association of Doctors of Medicine in California. Membership in the C. M. A. is not a prerequisite to the right to practice in this State.

"An understanding of fundamental principles, avenues of approach to your specific problems, limitation of authority of C. M. A. over individual members and its policies should first be understood and outlined.

FOUR BASIC PRINCIPLES

"Principles:

"1. C. M. A. believes in the principle of free choice of physician.

"2. C. M. A. recognizes the right of any individual or any group of individuals to select the type of medical care insurance program desired. Everyone is entitled to his free choice of medical care plans.

"3. C. M. A. stands and has always stood unalterably in favor of the provision by physicians of a high quality of medical care to patients; individual patients and those who are members of plans.

"4. C. M. A. is completely in accord with the principle that fees for services performed by physicians must be reasonable and related to the services performed and *not* to the amount or type of insurance available to the patients. C. M. A. recognizes there will be variations in fees because of geographical differences, varying degrees of training, skill, specialization and experience of physicians; differing conditions encountered in treating individual patients—usual versus unusual cases.

"The above principles represent tenets arrived at over C. M. A.'s many years of continued effort to protect and safeguard the welfare of all patients.

FOR THE PATIENT'S WELFARE

"C. M. A., guided by its democratically conceived organizational structure and its basic concepts as a voluntary association, cannot commit its individual members to comply with the regimentation suggested as the solution to your present problem. It should be understood that:

"1. The Association has no authority whatsoever to dictate to its members what fees they must accept for any particular service, whether it be service provided for an individual, a group, a trust fund; even for our own California Physicians' Service. Likewise, C. M. A. cannot direct nor does it desire to force its members to perform any services under fixed or arbitrary schedules of compensation.

"2. C. M. A. is unwilling to recommend to or urge upon its membership a service plan with a mandatory fee schedule except in cases of inadequate income.

"3. C. M. A. cannot make an agreement with any party, private or governmental, to the effect that its members will accept a predetermined schedule of fees as complete payment for services rendered. C. M. A. can recommend. C. M. A. cannot enforce. For example, the contract between the Department of the Army and C. M. A. implementing the provisions of Public Law 569 (MEDICARE) states that '. . . the Medical Association shall encourage physicians in the State of California to provide medical service for dependents of service personnel . . . a physician shall have the right to decline to participate under this program or to refuse any individual case without stating a reason therefor . . .'

"C. M. A. can and it willingly offers those services which are within its proper functions as a voluntary medical organization.

SERVICES OFFERED

"1. C. M. A. offers for the serious consideration of your trust funds our widely accepted

Relative Value studies which were developed after several years of careful analysis of medical services and surgical procedures. On the basis of your own experiences and statistical studies, it is our sincere belief that the application of these medical and surgical related values will help you to arrive at and establish a realistically integrated medical care program.

"2. C. M. A. offers its professional assistance to your trusts in reviewing your payment schedules in accordance with relative values.

"3. C. M. A. will continue to expand and emphasize (there are approximately four new physicians entering the practice of medicine each day in California) its program of urging physicians and patients to discuss *in advance* the prospective costs of surgical or other procedures. C. M. A. will cooperate with you to educate your beneficiaries on this phase of your problem.

"4. C. M. A. can and will urge its county medical societies to make their public service committees available to all trust fund administrators for the review of fees which appear to the administrators to be questionable. Such reviews, from our past experience, will result in (a) the satisfactory adjustment of fees in relation to services performed, or (b) give assurance to the trust fund administrator that, based upon impartial, professional analysis, the fees are justifiable.

COOPERATION SOUGHT

"In review, C. M. A. is aware of the problems and the responsibilities you have undertaken in selecting various forms of medical care insurance available on today's spiraling market; today's economy. We know that each plan offers advantages and disadvantages peculiar to its own operation and management.

"Your desire to obtain complete coverage for your members is quite understandable. However, your problem, the provision of medical and surgical services to a great number of people is not new. Though C. M. A. has been studying it for the past 40 years, we will be the first to admit that we do not yet have all the positive answers.

OFFER FURTHER DISCUSSIONS

"We believe that cooperation between trustees and C. M. A. is highly desirable. We freely offer you this cooperation in the sincere belief that it will bring about a better understanding of mutual problems.

"Our Executive Committee has been instructed to continue further discussion with you and to develop the proposals herein stated and any additional points disclosed. We are most sincere in our desire to work with you in the problems presented. We are positive that if we can continue our discussions in this atmosphere, we will mutually be assured of progress."

Do You Know? . . .

Dr. Charles B. Lewis was named "Citizen of the Year" as a climax to North Olmstead's annual homecoming celebration. A practicing physician in the community since 1929, he is mayor of the town, chief of staff at Berea Community hospital, past-president of the County Board of Health, member of the Kiwanis Club, past-master of the Masonic Lodge and member of several Masonic bodies.

* * *

Dr. Robert H. Ebert, professor of medicine and chairman of the Department of Medicine, Western Reserve University, Cleveland, has been appointed a member of the Veterans Administration Special Medical Advisory Group. The group meets quarterly to advise the Administrator of Veterans Affairs and the Chief Medical Director on the VA medical program. Another Clevelander, Dr. Charles C. Higgins, served in the group until the recent expiration of his term.

* * *

Dr. Ralph E. Dwork, director of the Ohio Department of Health, has been named to the 13-member National Advisory Committee on Chronic Illness and Health of the Aged, by Surgeon General Leroy E. Burney of the U. S. Public Health Service.

* * *

Dr. Edward L. Burns, Toledo, was named president-elect of the American Society of Clinical Pathologists at the organization's annual meeting in New Orleans.

* * *

Dr. Joseph B. Stocklen, comptroller of tuberculosis for Cuyahoga County, was honored with the Dearholt Medal at the annual 13-state Mississippi Valley Conference on Tuberculosis held recently in Omaha, Nebraska.

* * *

Dr. Geo. J. Hamwi and Dr. Edwin H. Ellison were presented plaques at a clinical congress of the American College of Surgeons in Atlantic City for their work on a film shown there.

* * *

Dr. Ollie M. Goodloe, who resigned as Columbus health commissioner to accept a similar post in Phoenix, Ariz., was presented an honorary membership in the Columbus Academy of Medicine.

* * *

The Canadian parliament has adopted an amendment to the Income Tax Act comparable to the Jenkins-Keogh bill, which the AMA and other professional organizations have been supporting. The Canadian limits of deferment are 10 per cent of earned income or $2,500 per year, whichever is the lesser. Under the Jenkins-Keogh bill, the limits would be 10 per cent of earned income or $5,000 instead of the $2,500 in the Canadian law.

Foreign Medical Graduates . . .

New Council Begins Its Work of Screening Doctors of Medicine from Abroad; How the Council Functions; First Examinations in February

AFTER nearly three years of planning, the Educational Council for Foreign Medical Graduates has placed an "open for business" sign on the door of its offices in suburban Evanston.

The council, which will carry out a detailed and comprehensive program for evaluating foreign medical school graduates, has offices in the Orrington hotel in Evanston. The executive director is Dr. Dean F. Smiley, Chicago, former secretary of the Association of American Medical Colleges.

A JOINT UNDERTAKING

It was decided three years ago that some form of evaluation service should be established within an independent agency whose affairs would be directed by a board of trustees designated by four cooperating organizations, the American Medical Association, the Association of American Medical Colleges, the American Hospital Association, and the Federation of State Medical Boards of the United States. For the next two years, the council will be supported by the four sponsoring agencies, the Kellogg Foundation, and the Rockefeller Foundation.

The council, incorporated in the State of Illinois, will be administered by a 10-member board of trustees—two representatives from each of the four sponsoring agencies and two persons representing the public at large, one named by the U. S. Department of Defense and the other by the U. S. Department of Health, Education and Welfare.

The president of the board is Dr. J. Murray Kinsman, dean of the University of Louisville School of Medicine.

HOW COUNCIL FUNCTIONS

Dr. Smiley said the council will distribute to foreign medical graduates around the world authentic information regarding the opportunities and difficulties involved in coming to the U. S. on an exchange student visa to take intern or resident training in a U. S. hospital, or coming on an immigrant visa with the hope of becoming licensed to practice.

The council will make available properly qualified foreign medical graduates, while still in their own country, all information on how to obtain certification. This involves a three-way screening process:

1. The council will certify that a student's educational credentials have been checked and found meeting minimal standards—18 years of formal education, including at least four years in a bona fide medical school, but excluding hospital training.

2. The council will certify that the command of English has been tested and found adequate for assuming an internship in an American hospital.

3. The council will certify that the general knowledge of medicine, as evidenced by passing of the American Medical Qualification Examination, is adequate for assuming an internship in an American hospital.

The council also will provide hospitals, state licensing boards, and specialty boards which the foreign medical graduates designate with the results of the three-way screening. It also will accumulate and publish each year complete data regarding the numbers and placement of foreign medical graduates in this country.

Dr. Smiley emphasized that the council will not serve as a placement agency either for interns or residents; it will not attempt to evaluate the teaching program or inspect or approve any foreign medical school, and it will not act as an intercessor for foreign medical graduates having problems under discussion by state boards of medical licensure or specialty boards.

FIRST EXAMINATION IN FEBRUARY

Dr. Smiley said that tentative plans call for the first American Medical Qualification Examination for foreign medical graduates already in this country to be held in either February or March 1958, and that the second such examination for foreign medical graduates both here and abroad will be held in either July or August.

Formation of the council was first announced last February at the 53rd Congress on Medical Education and Licensure in Chicago. It was the medical profession's answer to the mushrooming problem posed by the thousands of foreign-trained physicians now in the U. S.

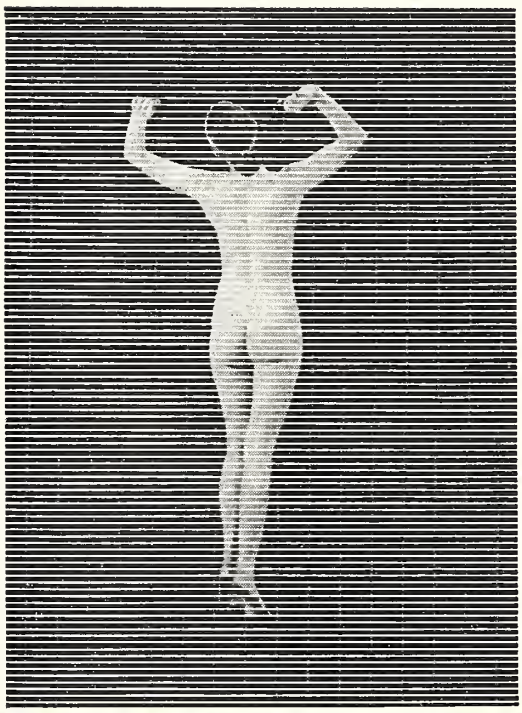
In discussing the council's work, Dr. Kinsman said that the screening process was initiated to help maintain the present high medical standards in the U. S. by making sure that foreign-trained physicians wishing to come here for hospital appointments or practice have reached a level of educational attainment comparable to that of students in approved American medical schools at the time of graduation.

"At the same time," he added, "the council hopes to encourage the well-trained foreign

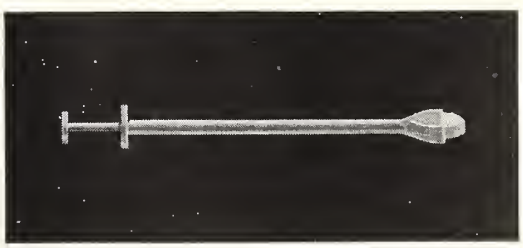
CHEMOTHERAPY PLUS FLORA CONTROL

Floraquin®

Destroys Vaginal Parasites
Protects Vaginal Mucosa







Vaginal discharge is one of the most common and most troublesome complaints met in practice. Trichomoniasis and monilial vaginitis, by far the most common causes of leukorrhea, are often the most difficult to control. Unless the normal acid secretions are restored and the protective Döderlein bacilli return, the infection usually persists.

Through the direct chemotherapeutic action of its Diodoquin® (diiodohydroxyquin, U.S.P.) content, Floraquin effectively eliminates both trichomonal and monilial infections. Floraquin also contains boric acid and dextrose to restore the physiologic acid pH and provide nutriment which favors regrowth of the normal flora.

Method of Use

The following therapeutic procedure is suggested: One or two tablets are inserted by the patient each night and each morning; treatment is continued for four to eight weeks.

Intravaginal Applicator for Improved Treatment of Vaginitis

This smooth, unbreakable, plastic device is designed for simplified vaginal insertion of Floraquin tablets by the patient. It places tablets in the fornices and thus assures coating of the entire vaginal mucosa as the tablets disintegrate.

A Floraquin applicator is supplied with each box of 50 tablets. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

SEARLE

physician to take advantage of the opportunities to further his education in this country."

There has been a continuing influx of foreign-trained physicians to the U. S. for a long time. At present, there are more than 6,000 such physicians in this country on temporary visas serving as interns or residents. All foreign-trained physicians here on temporary visas are supposed to return to their native countries on completion of their internship or residency training.

In addition, there is another group of approximately 1,000 foreign-trained physicians who enter each year as immigrants or as American citizens returning after completing their medical education abroad.

Second District Society Elects Officers

Dr. Maurice M. Kane, Greenville, was elected president of the Second District Medical Society at a meeting of district physicians with the 108th Founders' Day observance of the Montgomery County Medical Society. He succeeds Dr. Martin Cook, of Springfield.

Other officers elected were Dr. George Schroer, Sidney, vice-president; Dr. Frank W. Anzinger, Springfield (re-elected), secretary; Dr. W. H. Hanning, Dayton (re-elected), treasurer.

Medicare Payments Running at $5,000,000 Per Month Rate

In a speech on Medicare at the American Public Health Association meeting in Cleveland recently, Maj. Gen. Paul I. Robinson, executive director of the Medicare program, unveiled the following data regarding program:

As of the 1st of September, 137,286 claims had been received from Administrators paying hospitals, (total amount was $14,315,313) and 194,928 claims had been received from Fiscal Administrators paying physicians (total amount of $13,594,716). The Program is, at present, running at the rate of approximately $5-million a month. The Administrative costs vary from place to place but, in general, can be said to be running about 4.1 per cent.

Approximately 80 per cent of Medicare patients are female; the males being children under 14 years of age, generally speaking. Some 35 per cent of all cases have to do with maternity care; tonsillectomies account for about 17 per cent of the cases; abdominal surgery for approximately 9 per cent and orthopedic surgery for less than 2 per cent.

On the basis of an eight state study, the overall cost of the program, including physicians' and hospital bills, is $49.59 per patient day and the average patient hospital stay has been approximately five days per case.

Meeting of Northwestern Ohio Society Held at Defiance

Physicians attending the 113th meeting of the Northwestern Ohio Medical Association on October 23, voted to establish a by-laws revision committee to bring up to date the structure of the organization, which, according to Dr. James R. Jarvis, Van Wert, Councilor of the Third District, has not changed much since 1869.

The meeting was held this year at Defiance College, Defiance, and the report which recommended the changes was offered by Dr. Jarvis.

It was decided to hold next year's session in Tiffin. The following officers were elected: President, Dr. T. D. Efstation, Tiffin; Vice-President, Dr. Frank M. Wisely, Findlay; Secretary, Dr. Francis M. Lenhart, Defiance; and Treasurer, Dr. David L. Steiner, Lima.

This year's president, Dr. F. A. McCammon of Van Wert presided. His committee for the session included: Drs. J. F. Holtzmuller, G. L. Boomer, William S. Busteed, John D. Cameron, and Gerald A. Huber, all of Defiance. Dr. Harold C. Smith of Van Wert, was chairman of the nominating committee.

Speakers at the business meeting of the Association were: Dr. George A. Woodhouse, Pleasant Hill, OSMA President-Elect; Dr. Paul F. Orr, Perrysburg, OSMA Fourth District Councilor; Dr. Jarvis; and Mr. Hart F. Page, Columbus, OSMA Assistant Director of Public Relations. Guests included Dr. Edward J. McCormick, Toledo, past-president of the American Medical Association and of the OSMA; Dr. A. A. Brindley, Toledo, past-president of the OSMA; and Dr. Geo. J. Hamwi, treasurer of the Ohio State Medical Association. Dr. McCormick and Dr. Hamwi were program participants.

Speakers on the Scientific Program included, addresses of welcome by Dr. Holtzmuller, president of the Defiance County Medical Society and by Dr. Kevin McCann, president of Defiance College, co-host to the meeting; "Recent Advances in Pediatrics," Dr. Daniel V. Jones, Cincinnati; "Use of Orinase in Treatment of the Diabetic," Dr. Hamwi; "The Doctor as a Witness," Dr. McCormick; "Interviewing Techniques," Dr. Arik Brissenden, Cincinnati; "Treatment of Peptic Ulcer," Dr. Edward A. Marshall, Cleveland; and "Treatment of Obliterative Diseases of the Lower Extremity," Dr. John Cronley, Cincinnati.

Time To Plan Exhibits

It's time for medical societies to begin planning for 1958 county and state fairs. The AMA Bureau of Exhibits urges all medical societies to arrange for bookings of specific health exhibits as soon as possible. A number of commitments for some of the more popular exhibits have already been made.







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In Memoriam . . .

Eugene C. Beam, M. D., Sarasota, Fla.; University of Pittsburgh School of Medicine, 1912; aged 71; died October 11; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Beam practiced for many years in Columbus and was visiting in Columbus at the time of death. He retired in 1954 and moved to Florida. Dr. Beam was a member of Pi Delta Chi, Phi Alpha Sigma, several Masonic bodies, the Faculty Club and the Methodist Church. Surviving are his widow, a son, a daughter, two brothers and two sisters.

John J. Blue, M. D., Cedarville, Mich.; Wayne University College of Medicine, 1917; aged 66; died October 23. Dr. Blue formerly practiced in Fostoria and left there about 15 years ago. Surviving are his widow, a brother and a sister.

Emil M. Brudno, M. D., Cleveland; Medical College of Ohio, Cincinnati, 1901; aged 79; died October 15; former member of the Ohio State Medical Association. Dr. Brudno was a practicing physician for many years in Cleveland. In more recent years he divided his time between practice and assisting his wife in management of the Cleveland Civic Concert Association. Surviving besides his widow are a daughter and a brother.

John Hadley Caldwell, M. D., Newport, Ky.; Medical College of Ohio, Cincinnati, 1906; aged 78; died October 22. A practicing physician for many years in nearby Newport, Dr. Caldwell had many associations in the Cincinnati area. He was a member of the Masonic Lodge and the Presbyterian Church. His widow and a brother survive.

John B. Donaldson, M. D., Lorain; Western Reserve University School of Medicine, 1904; aged 75; died October 24; member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award; member of the American Medical Association; past-president of the Lorain County Medical Society. An early resident of Lorain, Dr. Donaldson returned there to practice upon completion of his internship in Cleveland. His more than a half century in the profession included 25 years as pathologist at St. Joseph Hospital. He was a charter member of the local Lions Club and a member of the Presbyterian Church. Surviving are his widow, a daughter and a brother.

Theodore G. Duncan, M. D., Cleveland; Cleveland-Pulte Medical College, 1911; aged 71; died November 10; member of the Ohio State Medical Association, through 1954. Dr. Duncan was for 40 years associated with the Department of Contagious Diseases for the Cleveland City Health Department. He was chief of that department from 1929 to his retirement in 1954. Survivors include his widow and a daughter.

Glen Keith Folger, M. D., Cleveland; University of Nebraska College of Medicine, 1930; aged 52; died October 23; member of the Ohio State Medical Association, the American Medical Association, Central Association of Obstetrics and Gynecology; Fellow of the American College of Surgeons and diplomate of the American Board of Obstetrics and Gynecology; past-president of the Cleveland Society of Obstetricians and Gynecologists; one of the original members of the OSMA Committee on Maternal Health. Dr. Folger began his practice in Cleveland in 1932. From 1942 to 1945 he served with the Air Force and attained the rank of lieutenant colonel. He was a member of Delta Chi, Nu Sigma Nu and the Presbyterian Church. Surviving are his widow, two sons and his parents.

William McConky Keller, M. D., Akron; Jefferson Medical College of Philadelphia, 1939; aged 45; died October 29; member of the Ohio State Medical Association, the American Medical Association, and the Akron Pediatrics Society. During World War II, Dr. Keller served with the Army Medical Corps. He had been practicing in Akron since the war and was on the staff of Children's Hospital. Among organizations to which he belonged were the Congregational Church, the University Club and the Fairlawn Country Club. Survivors include his widow, a daughter and a son.

Elmer Thomas Kuhn, M. D., Columbus; Ohio Medical University, Columbus, 1901; aged 84; died October 18; member of the Ohio State Medical Association through 1947, and recipient of the OSMA 50-Year Award. Dr. Kuhn served all of his professional career in Columbus and retired only four years ago. He was a member of several Masonic bodies and the Methodist Church. Surviving are his widow, a son and two sisters.

Harry A. Martin, M. D., Gratiot; Eclectic Medical College, Cincinnati, 1905; aged 85; died October 26; member of the Ohio State Medical Association through 1954, and recipient of the OSMA 50-Year Award; past-president of the Muskingum County Medical Society. Dr. Martin practiced in the Gratiot area from 1905 until his retirement about four years ago. He was a member of the Methodist Church. Surviving are his widow and two sons.

Fitz Melvin C. Payne, M. D., Dayton; Meharry Medical College, 1918; aged 69; died October 16; member of the Ohio State Medical Association through 1953. Dr. Payne practiced in Tulsa, Okla., from 1921 to 1941, when he first moved to Dayton. He later moved to Cleveland and re-

turned to Dayton in 1956. He was active in a number of organizations and was a lay-leader in the Episcopal Church. His widow and a son survive.

Daniel C. Rivers, M. D., Cincinnati; University of Cincinnati College of Medicine, 1929; aged 51; died October 17; member of the Ohio State Medical Association, the American Medical Association; Fellow of American College of Physicians; diplomate of the American Board of Internal Medicine. A native of Cincinnati, Dr. Rivers served all of his professional career there with the exception of time in residency training. Surviving are his widow, five daughters and a brother.

Adah Mighton Rowland, M. D., Cleveland; aged 86; died November 5. Dr. Adah Rowland was the widow of Dr. Justin Rowland who died in 1939. She and her husband entered practice together in the Euclid area, she later devoting all of her time to family cares. Five sons survive, one of whom is Dr. Guy Rowland who practiced in Cleveland but is now in Florida.

Charles J. Ryan, M. D., Dayton; Ohio State University College of Medicine, 1913; aged 69; died October 19; member of the Ohio State Medical Association and the American Medical Association. Dr. Ryan practiced for many years in Dayton, retiring in 1954. He was a veteran of World War I, having served with the Army Medical Corps. Surviving are his widow and two sisters.

Karl E. Schneerer, M. D., Norwalk; Bennett Medical College, Chicago, 1904; aged 77; died October 9. Dr. Schneerer practiced for about 40 years in Norwalk before he went into semi-retirement about 10 years ago. His only immediate survivor is his son, Dr. Fred Schneerer Gardiner, of LaMesa, Calif.

Oscar J. Viksnins, M. D., Springfield; University of Vienna School of Medicine, Austria, 1914; aged 70; died October 9. A native of Latvia, Dr. Viksnins came to this country in 1951. He was resident physician at Springfield City Hospital from 1952 to 1956. His widow survives; also other relatives overseas.

Gaillard P. Willett, M. D., Elmore; University of Michigan Medical School, 1918; aged 65; died October 8; member of the Ohio State Medical Association through 1952. A native of Elmore, Dr. Willett practiced in that vicinity for 37 years. His home was at Elliston. Activities included service on the Ottawa County Board of Health. Surviving are his widow, a son, a daughter and a brother.

In spite of a 15 per cent reduction in fatal accidents among persons aged 65 and over in the last six years, accidents in this group still account for more than 25,000 lives each year in the United States.—Metropolitan Life.

Observations on Inside Russia Related By AMA President-Elect After Tour of Country

AMA President-Elect Gunnar Gundersen, La-Crosse, Wis., wrote an interesting and informative 17-page story of his experiences in Russia. Dr. Gundersen and Dr. Edwin S. Hamilton, Kankakee, Ill., chairman of the AMA Board of Trustees, and their wives spent 11 days in Russia before going to Istanbul for the meeting of the World Medical Association.

Dr. Gundersen, while in Chicago for the Board meeting recently, said the trip was "a wonderful experience," but added that he was glad it ended when it did. "An Iron Curtain country it truly is; a police state without question," he said.

Here are a few excerpts from Dr. Gundersen's lengthy article:

"Russia has a population of roughly 200,000,000. There are 360,000 physicians. Medical education is conducted in about 80 medical schools. They admit that production is satisfactory, but that the distribution is not satisfactory. For instance, in the medical school at Moscow there are 4,500 students in a six-year course so there are about 500 or 600 graduates annually. The course begins after preliminary education at the age of 18. Following completion of the course students graduate as physicians but not doctors of medicine. Ten per cent of the graduates go on into a three-year continuation course and 90 per cent go out as general practitioners in the various areas.

"We were told that the supply of physicians is adequate from these 80 schools, but the distribution is not satisfactory. Consequently, incentive pay for practicing in undesirable locations is necessary.

"Engineering seems to be the most preferred profession. The hospitals seem crowded. The beds were together and the wards contained up to 30 people. Two-bed and four-bed rooms were quite common in the neurological institute which we visited. The number of hospital beds per population was not obtained. It seemed that they were unwilling or unable to give us this information. . . . The work being done seems to be of a high order by able men working under rather difficult and cramped conditions.

"One neurosurgeon was doing a nerve tumor and after the exposure got into troublesome bleeding requiring blood. Blood was not available or was not being given to cover the loss. Consequently, the procedure had to be stopped and he was to do the actual operation at a later session two weeks hence after the patient recovered. He successfuly succeeded in ligating the lateral sinus and stopping the bleeding before the first procedure was started.

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(Continued on Page 1478)



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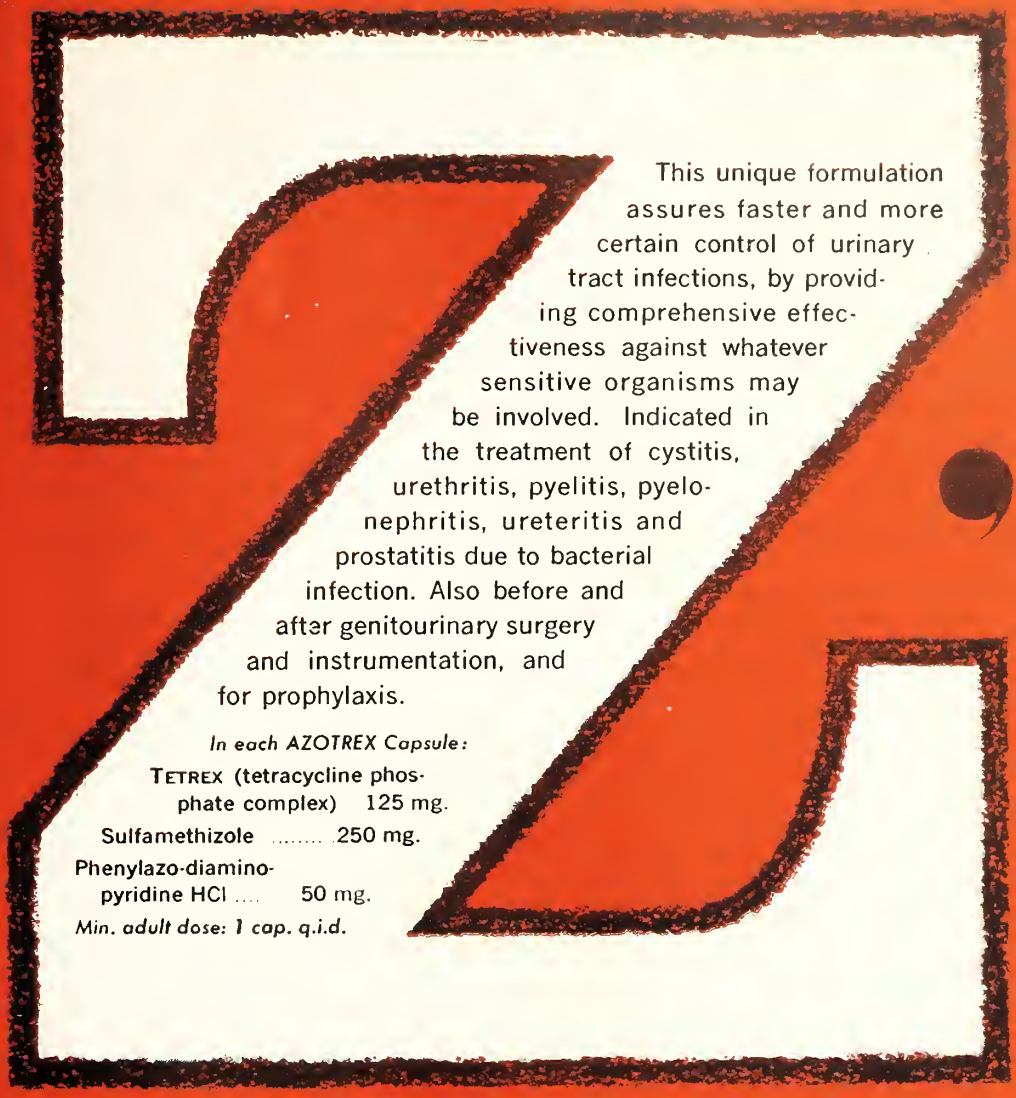
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CAPSULES

men and they can be seen working on construction jobs, as street sweepers and in nearly every type of hard work. There seems to be much manufactured work in Russia reminiscent of the W. P. A. days in this country.

"During our stay in Russia we did not see one car which we could identify as a privately owned one. They claim to be making 400,000 cars a year, most of which are trucks and which are most essential for the economy. The trolleys and busses seem excellent. In Moscow, as elsewhere in Russia, everyone looks exactly the same; that is drab. No decent clothes are worn. There is no evidence of prosperity. The hotels are old and poorly maintained. The elevators are of an old vintage, hand-operated. Busts and paintings of Stalin and Lenin are everywhere in evidence.

"The press is completely controlled by Pravda and Izvestia and people apparently are only allowed to read what the dictators want them to.

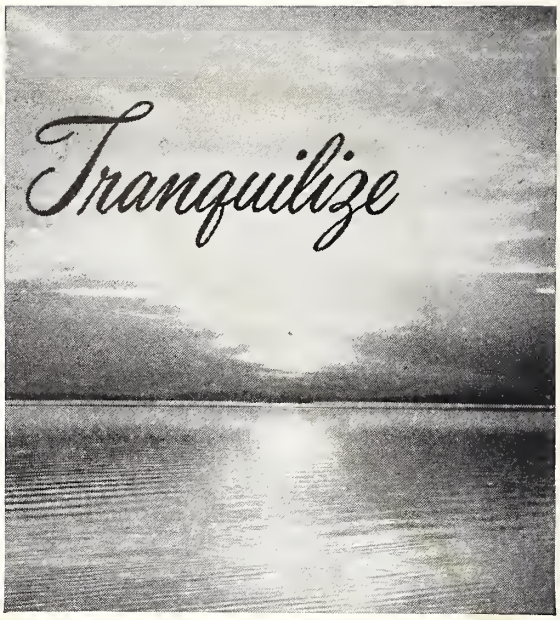
"Favorable impressions in Russia are certainly many, particularly the ballet and opera and their efforts to provide for children. Cleanliness on the streets is very good, but the markets where food and meats are sold are unspeakable.

"One is impressed with the bragging which takes place on the part of the Intourist guides over everything Russian. Everything is the biggest and the Russians made all the inventions, etc. The churches, which have been abolished and are now to a large extent religious museums only of historical interest, were open and seemed to be well attended. The shops are not impressive. They look for everything in the world like a bargain counter. They are crowded. The prices are high. An ordinary suit costs about $200 but nobody has the $200.

"After having spent only 11 days in the 'Worker's Paradise' it would seem to me that folks who are interested in extension of the welfare state should go to Russia to see what the situation really is like. It is quite obvious that with the total welfare state, freedom ceases to exist. There is no question but what it tends to level everybody downward. It certainly fails to upgrade anything except that possibly it does spread whatever goods there are to a larger number of people. If this represents an improvement over what the conditions were before the revolution then one can only say that the conditions at that time must have been unspeakable.

"We were told by people in the embassy service that they have no freedom of movement whatsoever."

Dr. Charles H. Rammelkamp, Jr., has been named chief of medicine at City Hospital, Cleveland, the post held by the late Dr. Roy W. Scott, Nationally recognized in his field, Dr. Rammelkamp has been director of research at City Hospital since 1950.



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Activities of County Societies . . .

First District

(COUNCILOR: FRANK H. MAYFIELD, M. D., CINCINNATI)

ADAMS

Dr. Frank H. Mayfield, Cincinnati, First District Councilor, addressed members of the Adams County Medical Society on October 30 at the Adams County Hospital, West Union.

BUTLER

"Accidental Poisoning in Children," was the subject of a talk presented at the regular meeting of the Butler County Medical Society on October 31 in Middletown. The speaker was Dr. Harry C. Shirkey, assistant professor of pediatrics at Children's Hospital, Cincinnati.

CLINTON

The Clinton County Medical Society played host to the County Bar Association at the monthly luncheon on October 1. The AMA movie, "The Doctor Defendant" was shown.

At the business meeting which followed the general meeting the series of talks to senior high school students was discussed. It was agreed that the subjects should be similar to those used last year. Speakers for the series were the following: Dr. E. K. Yantes, Dr. H. Richard Bath, Dr. John K. Williams, Dr. Nathan S. Hale, Dr. Maxine Hamilton, Dr. Arthur F. Lippert and Dr. Mary Boyd.

It was noted that in the new telephone directory a number for emergency medical service is listed.

HAMILTON

"Estate Planning for Doctors," was the subject of a symposium presented by the Academy of Medicine of Cincinnati on November 19. The following speakers and topics were featured on the program:

"The Multiple Purpose of Life Insurance in Estate Planning," Myron T. Jenings, manager, Pension and Employee Benefit Department, the Union Central Life Insurance Company, Cincinnati.

"Investing in Common Stocks Is Part of a Professional Man's Over-All Financial Planning." Lawrence S. Fitzgerald, manager, Cincinnati Office, Merrill Lynch, Pierce, Fenner & Beane.

"The Mechanics of Estate Planning for Doctors," Halsey G. Bechtel, Jr., trust officer, The Central Trust Company, Cincinnati.

Specialty Societies of the Greater Cincinnati area which held meetings in addition to the regular Academy meetings were the following:

Cincinnati Surgical Society,

Southwestern Ohio Society of General Physicians,

Ohio Valley Proctologic Society,

Cincinnati Society of Internal Medicine,

Cincinnati Obstetrical and Gynecological Society,

Cincinnati Orthopaedic Club,

Cincinnati Oto-Laryngological Society,

Cincinnati Society of Neurology and Psychiatry,

Radiological Society of Greater Cincinnati,

Cincinnati Dermatological Society.

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

MIAMI

The Miami County and the Shelby County Medical Societies jointly sponsored a program in cooperation with Dettmer, Stouder, Piqua and Wilson Memorial Hospitals. The meeting was held the afternoon of November 8 in the Elks' Building, Piqua, followed by dinner.

Speaker was Dr. George J. Thomas, chairman of the Department of Anesthesiology, University of Pittsburgh College of Medicine, whose subject was "Anesthesia Explosions."

Surgical and obstetrical staff nurses were guests at the meeting.

MONTGOMERY

Following is a report of the October 9 program as contained in the Society Bulletin:

Twenty-four former presidents of the Montgomery County Medical Society were given special recognition at the Annual Founder's Day Observance of the Society on October 9. They were guests of the Society for the occasion. Each received from M. C. M. S. President, Dr. R. Dean Dooley, a newly designed Past President lapel button, which replaces the key formerly awarded. In his remarks, Dr. Dooley expressed appreciation for the many years of medical leadership given by the group. He closed with a poem which he said exemplifies the Past Presidents' work as "builders of a medical organization which has smoothed the way for present and future generations of physicians in the practice of medicine in this community."

The Dayton Obstetrical and Gynecological Society met on November 20 at the Van Cleve Hotel for a social hour, dinner and a program. The speaker was Dr. T. Brent Wayman, associate clinical professor of surgery (urological), University of Cincinnati, whose topic was "Urological Complications in Obstetrics and Gynecology." Moderator was Dr. R. T. Sauer.

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

ALLEN

Development of cooperation between the medical and legal professions was outlined on Octo-

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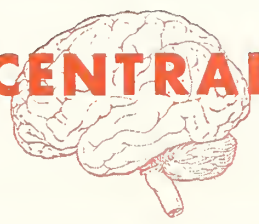
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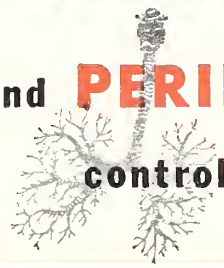
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ber 15 at a meeting of the Lima and Allen County Academy of Medicine with members of the Allen County Bar Association as guests.

Speaker was Wayne Stichter, Toledo, attorney for the OSMA, who discussed medico-legal problems. The film "Medical Witness" was shown and Mr. Stichter discussed the joint principles adopted on the state level by the OSMA and the Ohio Bar Association.

AUGLAIZE

Dr. Robert J. Herman, Wapakoneta, was elected president of the Auglaize County Medical Society, to succeed Dr. William V. Barton, St. Marys on January 1. Dr. Michael Rabe, New Bremen, was elected vice-president, and Dr. Robert Oyer, Wapakoneta, secretary-treasurer.

Dr. Harry Geisler was chosen for the Board of Censors, Dr. E. Y. Kuffner, delegate, and Dr. E. E. White, alternate.

Fourth District

(COUNCILOR: PAUL E. ORR, M. D., PERRYSBURG)

LUCAS

Following were features of the Academy of Medicine of Toledo program for November:

Specialties Section, November 1—"The Doctor Defendant," a joint meeting of physicians and lawyers.

General Section, November 8—"Medical Radiation Hazards and the Responsibilities of the Medical Profession," Dr. J. Robert Andrews, chief of the Radiation Branch, National Cancer Institute.

Medical Section, November 15—"Treatment of Terminal Carcinoma," Dr. Michael J. Brennan, physician-in-charge, medical oncology, Henry Ford Hospital, Detroit.

Inter-Hospital Postgraduate Lecture Series, November 21-22—"Diseases of the Digestive Tract," Dr. Sara M. Jordan, director, Department of Gastroenterology, Lahey Clinic, Boston, Mass.

PUTNAM

First autumn meeting of Putnam Society was held at Hotel Dumont, Ottawa, Tuesday, Sept. 3.

Guest speaker was Dr. Lee Bartholomew, internist, of Lima. Dr. Bartholomew discussed recent advances in antibiotic therapy, mentioning particularly the broad spectrum antibiotics and the importance of their proper selection. Bacterial mutations and patient sensitivity were also discussed.—H. N. Trumbull, M. D., Correspondent.

WOOD

The Wood County Medical Society held its regular dinner meeting on October 17 at the Midway Restaurant, Bowling Green.

Dr. Frederick H. Wentworth, medical coordinator of disease control activities of the Ohio Department of Health, discussed "Rheumatic Fever Control Program in Ohio," and Dr. Nathan P. Eisenberg, medical director of services for crippled Children, Ohio Department of Public Welfare, described the services offered by his department's Diagnostic Cardiac Clinics. The Woman's Auxiliary also held its meeting.—R. L. Pease, M. D., Secretary-Treasurer.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

ASHTABULA

The doctors of Ashtabula County were guests of the Ashtabula County Ministerial Association on October 29. Purpose of the meetings was to discuss common problems in the field of health and religion. A similar meeting between clergymen and physicians was held last year.

CUYAHOGA

Outstanding work in promoting the Salk vaccine program for school children won an award for the Academy of Medicine of Cleveland. A plaque was presented by Probate Judge Frank J. Merrick, chairman of the Cuyahoga County Chapter of the National Foundation for Infantile



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1. Hodges, F. T.: GP, *14*:86, Nov., 1956.

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Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

STARK

Dr. John R. Graham, chief of the medical service at Faulkner Hospital, Boston, was guest speaker at the November 14 meeting of the Stark County Medical Society in Canton. His subject was, "Classification of the Different Types of Headache and the Mechanism of Each."

In regard to the Sixth District Postgraduate Day held in Canton on October 23, the Stark County Medical Society newsletter reported: "According to impartial observers, the recent Sixth Councilor District Postgraduate assembly held at Canton was the finest meeting we have held to date. . . . The President would like to thank Dr. Howard Ickes, general chairman and all of his committees, also the members of the Auxiliary, whose efforts were so vital in making this so successful. The splendid attendance by our own Society members was also a great factor in making this a success and is greatly appreciated."

SUMMIT

Two members of the staff of Cleveland Clinic were guest speakers at the October 1 meeting of the Summit County Medical Society. Dinner was served at the Akron City Club after which the meeting was held in the Akron General Hospital auditorium.

Dr. Howard P. Taylor, co-head of the Department of Obstetrics and Gynecology, spoke on "Nausea and Vomiting of Pregnancy; Hyperemesis Gravidarum."

Dr. Albert C. Lammert, member of the obstetrics and gynecology staff, spoke on "Recent Trends in the Conduct of Normal Labor; Changing Concepts in the Use of Analgesia and Anesthesia in Normal Obstetrics."

The Summit County Day Dinner Dance was held on October 12 at the Fairlawn Country Club for members and their ladies.

The scientific program for the November 5 meeting of the Summit County Medical Society consisted of a talk by Dr. John H. Talbott, professor of medicine, University of Buffalo School of Medicine. His subject was, "Gout and Gouty Arthritis."

Dinner was served at the Akron City Club after which the meeting was conducted at the Akron General Hospital Auditorium.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

The Belmont County Medical Society met on October 17 in the Martins Ferry Hospital where dinner was held and a program was presented by the hospital staff.

COSHOCTON

Doctors of five counties, Muskingum, Tuscarawas, Guernsey, Holmes and Coshocton met on October 8 in the new Coshocton County Memorial Hospital in conjunction with the October meeting of the Coshocton County Medical Society.

Speaker for the event was Dr. Geo. J. Hamwi, associate professor of medicine at Ohio State University, whose subject was "Endocrinology and General Practice." Following a tour of the new hospital, refreshments were served.

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D., LANCASTER)

FAIRFIELD

Dr. Frank H. Mayfield, Cincinnati, Councilor for the First District, presented a paper on "Medicine and the Law" at the meeting of the Fairfield County Medical Society held in Lancaster on October 10.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

The announced program for the November 11 meeting of the Scioto County Medical Society called for a discussion of the subject "Forma-



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tion of a Tumor Conference." The program was arranged by Dr. B. U. Howland at the General Hospital, Portsmouth.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

The Columbus Academy of Medicine has launched a long-range program urging doctors to participate regularly in the giving of blood through the Red Cross Blood program. The initial roster of those who donate regularly included 76 physicians—among them 11 "Gallon Club" members. Other names will be added as the program progresses.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

Two physicians were honored for their service to the community during 50 years in the medical profession at the October 8 meeting of the Lorain County Medical Society at the Oberlin Inn, Elyria. Each was presented the 50-Year Award of the OSMA.

Those honored were Dr. F. M. Sponseller, Elyria Township, and Dr. L. H. Trufant, Oberlin. Physicians and their wives attended the dinner meeting.

The regular monthly meeting of the Lorain County Medical Society was held November 12, at Oberlin Inn. The society had as guests the members of the Lorain County Bar Association. Approximately 130 members and guests were present at one of the largest turnouts in the history of the society.

Speaker of the evening was Dr. Lester Adelson, pathologist and chief deputy coroner for the County of Cuyahoga. His well accepted and interesting speech pertained to sudden death as related to the coroner.

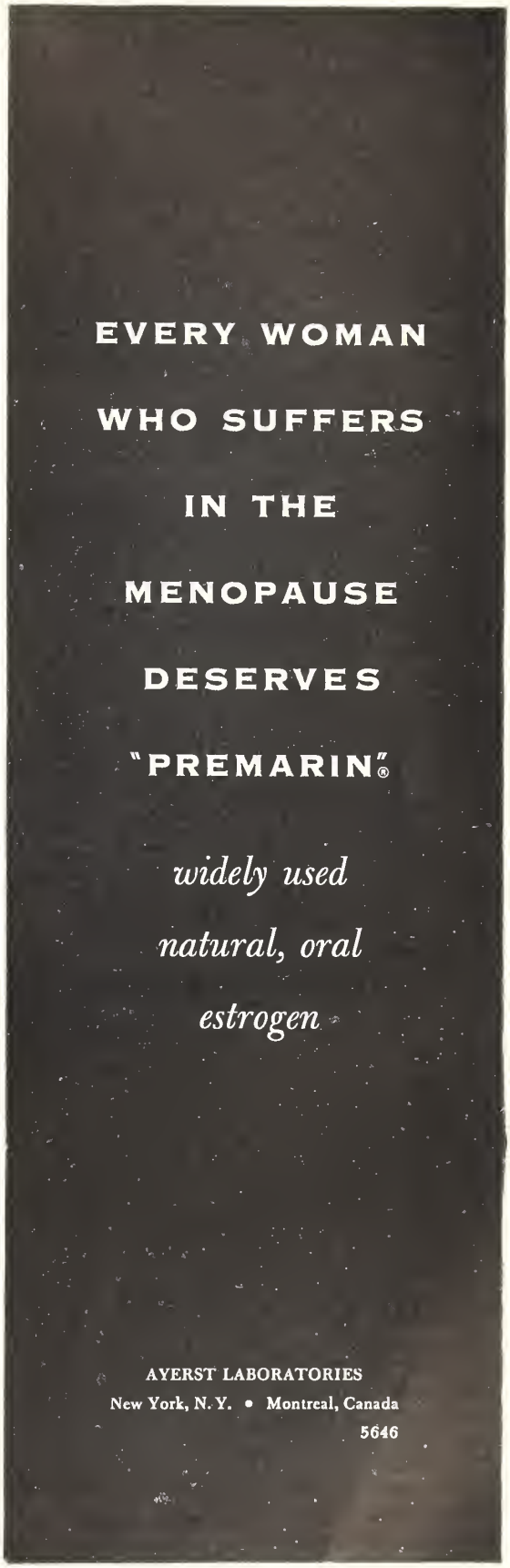
The joint expression of those present at the dinner meeting was that it was a most successful meeting, and it is hoped that such an affair will be repeated.—Conrad T. Rusin, M. D., Secretary-Treasurer.

Cincinnati Will Be Host to the Midwest Conference on Rheumatic Diseases

The fifth annual Midwest Conference on Rheumatic Diseases will be held in Cincinnati at the Hotel Alms, McMillan and Victory Parkway on Sunday, December 15.

National authorities in the field of rheumatic disease will participate. Sponsors of the conference include the Central Rheumatism Society, Cincinnati Rheumatism Society, Cincinnati Orthopedic Society, University of Cincinnati College of Medicine and the Ohio Valley Chapter of the Arthritis and Rheumatism Foundation.

Physicians who wish to attend are invited to contact Dr. Joseph E. Levinson, program chairman, 771 Doctors Building, Cincinnati 2, Ohio.



Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. C. H. Bell, 754 Dickson Parkway, Mansfield
(See Page 1377 for roster of officers.)

COLUMBIANA

Members of the Woman's Auxiliary to the Columbiana County Medical Society were guests of the Mahoning County Auxiliary for luncheon on October 18, at the Tippecanoe Country Club in Youngstown. (See details under Mahoning County.)

CUYAHOGA

Harvest time finds Auxiliary reaping the fruits of its summer endeavors. The Health Card is well planted in the community, Musicarnival tickets are sprouting into money trees and the year's program is thoroughly cultivated to bring a succession of bloom throughout the winter.

Invitations were mailed to 2000 Academy wives to attend the afternoon tea held at the Women's City Club, October 9. New members and prospective members were given the red carpet treatment by all the old hands who planned the event especially to capture the interest of the uninitiated. Mrs. V. R. Frederick, State President, addressed the group. Fran Bryand and Lauretta Luther, a gifted pair of musicians, did an act called "The Pitfalls of Songwriting."

The Auxiliary is proud of the achievement of Mrs. Garry Bassett, member of the steering committee for her five years' volunteer service with the Red Cross.

ERIE

A luncheon at Providence Hospital was enjoyed by the members of the Woman's Auxiliary to the Erie County Medical Society, as guests of Sister M. Lucia, administrator. A program arranged by Miss Catherine O'Neil, medical records librarian, followed.

Mrs. Elizabeth Baker, who is in charge of hospital and institutions department of the Cleveland Public Library, talked on the work being done in Cleveland by volunteers who make books available to patients in hospitals and institutions. They also distribute books to shut-ins and handicapped people who are unable to visit public libraries. A film entitled "The Winged Bequest" was shown. The film sponsored by the Cleveland Foundation has been shown worldwide to groups interested in promoting better library service to the hospitals in their community.

Sister Lucia expressed her appreciation to members of the Auxiliary for maintaining the bookcart at Providence Hospital. The cart, featuring current magazines and books, is taken to the patient's rooms twice weekly by a member of the Auxiliary, offering free reading material. The service is also maintained at Good Samaritan Hospital.

During the business meeting, the Health Careers Committee reported that drapes were made and hung in the Student's Lounge of the Providence School of Nursing. Films have been shown to the Future Nurses' Clubs of Sandusky and St. Mary's High Schools. Honorary membership was extended to Mrs. H. L. Sowash.

FAIRFIELD

Mrs. George LeSar, president, conducted the autumn business session at the Lancaster Country Club, Tuesday, October 8, for the luncheon meeting of the Woman's Auxiliary to the Fairfield County Medical Society. Mrs. G. F. Jones gave a report of the Fall Conference. Mrs. Galon Rodabaugh urged support of the school bond issue and in this connection the Auxiliary members donated $27.00 to the "Citizens Committee for Better Schools." As Nurse Recruitment chairman, Mrs. Rodabaugh commented on the activities of the Future Nurses' Club.

Mrs. Frederick W. James, Eighth District Director, gave the highlights of the annual district meeting held October 3 in Marietta. Sixteen members from Fairfield County were present for this meeting.

MAHONING

An interesting account of his own career by Dr. Nicholas Dallas, Toledo, held the attention of about 200 women on October 17 at Tippecanoe Country Club. The occasion was the luncheon sponsored for six area women's groups by the Woman's Auxiliary to the Mahoning County Medical Society. Dr. Dallas is the creator of the fictional characters, Rex Morgan, M. D., and Judge Parker.

Mrs. Cary S. Peabody, President, welcomed members of the hostess group and members of the Woman's Auxiliary to the Mahoning County Bar Association, the Auxiliary to the Corydon-Palmer Dental Society, Auxiliary to the Professional Engineers, League of Women Voters, Junior League of Youngstown and the Auxiliary to the Columbiana County Medical Society.

The Invocation was given by Mrs. Frederick S. Coombs, Jr. Welcomed as special guests were Dr. Andrew Detesco, president-elect of Mahoning County Medical Society, and Dr. John McDonough, public health chairman, who asked for support of the public health amendment on the fall ballot.

Program chairman was Mrs. Edward G. Rizk and social chairman, Mrs. Edward M. Thomas.

ROSS

Woman's Auxiliary to the Ross County Medical Society had a dinner and meeting on October 8 at the Lynne House. Mrs. Robert Swank presided and Mrs. William J. Corzine, Jr., program chairman, introduced Mr. William Maull, representative

of the Citizens Advisory Committee for the school bond issue.

Mrs. Swank introduced a new member, Mrs. Carl Henderson. Mrs. Walter Kramer reported on plans for the District 10 meeting. Mrs. John Franklin, Sr., conducted the meeting of the Hospital Guild 1 which followed.

Chillicothe is to have a Stork Club. According to Mrs. Jane Hertenstein, superintendent of the Chillicothe Hospital, first time mothers will have the opportunity to enroll in the Stork Club, sponsored by the Ross County Medical Society Auxiliary. By doing so, the expectant mothers will know what to expect when they are admitted to the hospital's maternity ward. The new mother may enroll by filling out printed cards in the offices of local physicians and mailing them to the hospital. The Auxiliary has arranged for meetings to be held at the hospital where the mothers will meet the personnel on the maternity floor. A course of four lectures will be given by the head nurses. The course has no connection with the medical aspect of her case. Any expectant mother may fill out a card and mail it to the hospital. Upon receipt, a member of the Auxiliary will call at the sender's home.

SCIOTO

The 17th birthday anniversary luncheon at Harold's highlighted the October 16 meeting of the Woman's Auxiliary to the Scioto County Medical Society. Mrs. William Hugenberg, president, introduced City Manager George Mingle as guest speaker. Mr. Mingle reviewed his experiences in the State Highway Patrol as related to state and national governments.

The program, stressing the importance of public relations, was planned by Mrs. B. U. Howland and her committee. Mrs. Howland introduced representatives of local health organizations who were special luncheon guests of the Auxiliary. Those present were Dr. Howard Baughman, Jr., chairman of the Heart Fund; Gene Crawford, city health commissioner; and other organizations represented were: Mental Health, Mentally Retarded Children, Fresh Air Camp, Cancer Fund, Red Cross, Tuberculosis Assn., Social Hygiene, March of Dimes and Mrs. V. W. Luchi, president of Mercy Hospital Guild. Mrs. George Cooper, Ninth District director of the State Auxiliary, and Mrs. S. L. Meltzer, 1st Vice-President of the State Auxiliary were present.

Past-presidents of the Scioto Auxiliary were given special mention. Entertainment was furnished by the Girl's Glee Club of Mercy Hospital School of Nursing.

STARK

October was a busy month for the Woman's Auxiliary to the Stark County Medical Society. The year's activity began with a luncheon on October 15 at the Alliance Woman's Club with the Alliance doctors' wives as hostesses.

Mrs. Lloyd Dowell, vice-president, presided at the business meeting and in behalf of the

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Auxiliary, accepted an award made at the national convention for being one of the six Ohio counties donating more than $1000.00 to the A. M. E. F. last year. Mrs. Wm. Farrar was present in New York as the state chairman for the fund and had accepted the honor for Stark County.

On October 26 the Auxiliary had a parcel post booth in the St. Marks Talent 'n Treasures booth in the Canton Municipal Auditorium. The booth sold out rapidly and netted about $325.00 for A. M. E. F. Mrs. David Leavenworth, chairman, was ably assisted by her committee of nine auxiliary members.

TRUMBULL

Nearly fifty members of the Trumbull County Medical Auxiliary met for a luncheon at the Prentice Tea Shop of the Uptown Restaurant.

Mrs. John Thomas and Mrs. George Sudimack, co-hostesses for the afternoon, were in charge of the pre-luncheon punch bowl, welcoming all guests, but especially the honorary members—Mrs. A. F. Compton, Mrs. R. B. Dobbins, Mrs. B. E. Goodman, Mrs. W. W. McKay, and Mrs. J. R. Willoughby, Sr.

Mrs. Clyde Muter, president, presided at the business meeting. Mrs. Thomas Wilson introduced the speaker, Mrs. George E. Barker, who gave an engaging talk on Christmas table favors and holiday party foods.

UNION

The Union County Medical Auxiliary members and guests enjoyed a luncheon for their October meeting in the Catholic Parish Hall. Mrs. Angus MacIvor, president, welcomed the guests and presented the program chairman, Mrs. Fred C. Callaway, who introduced the speaker, Dr. Nellija Rubenis. Dr. Rubenis, a native of Latvia, is director of the Tri-County Mental Health Clinic. Others introduced who made brief remarks were Mrs. V. R. Frederick, state president, from Urbana; Mrs. Frances Helmick, administrator of Union County Memorial Hospital; Mrs. Mary Mills, president of the Hospital Auxiliary, and Miss Evelyn Braun, senior health nurse of Union County.

Ohio Academy of General Practice Officers for 1957-1958

Officers of the Ohio Academy of General Practice, announced following the Annual Session in Columbus, are the following: President, Dr. Carl C. Van Horn, Cincinnati; president-elect, Dr. Charles R. Marlowe, Toledo; past-president, Dr. Roscius C. Doan, Miamisburg; treasurer, Dr. Howard R. Mitchell, Sr., Columbus.

Speaker is Dr. Lewis W. Cellio, Columbus, and vice-speaker, Dr. Roger A. Peatee, Bowling Green. Delegates are Dr. Herbert W. Salter, Cleveland, and Dr. Cellio; and alternates, Dr. William J. Hartlage, Sciotoville, and Dr. Jay B. Price, Cleveland. Executive Secretary is Dr. Earl D. McCallister.

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AMA President Urges Final Drive On Polio Immunizations

A cleanup operation to contact stragglers who have not followed up on their polio immunizations, is urged in the following letter from AMA President David B. Allman to physicians. Reminder cards to be mailed to patients are available as indicated in the letter.

"This letter gives me an opportunity to do something I've wanted to do for a long time—thank you for the enthusiasm and cooperation with which you responded to the AMA campaign against polio. The real significance of that response lies in the incidence of polio this year. By October 10, the number of paralytic polio cases for 1957 was down 70 per cent from last year's total for the same period. You have played an important role in the fight against one of America's most dread diseases. That is something to be proud of!

"But the fight isn't over. There are still over 37 million people under 40 years who have not yet received their first injection. About 44 million more need second or third shots. With vaccine supplies once again plentiful (over 13,000,000 cc. are being released monthly) it's time to step up immunization activities.

"With this letter you will find two cards (sent with original letter)—one urging your patients to begin their vaccination series if they haven't already done so, the other reminding those who are ready for their third shots. They are designed for you to send directly to your patients, either enclosed in an envelope or addressed and stamped on the reverse side and mailed as a postcard. If you fill out and return the enclosed order form, **the AMA will send you free as many of these cards as you can use.**

"This is a cleanup operation—one we hope will round up all the stragglers not yet brought in by previous promotional efforts. The AMA Committee on Poliomyelitis—headed by Dr. Julian Price—feels that **the final push should come from the individual physician through direct contact with his own patients.** These reminder cards will be an effective way for you to contact your patients, directly.

"We shouldered a big responsibility in January when we launched the polio vaccination campaign. But the job was well worth it. American doctors, by taking the lead in this drive, have shown themselves public-spirited citizens, sincerely concerned with the nation's health. It is our hope that this project will be the last big push necessary, and that polio will soon take its place with diphtheria and whooping cough as a routine immunization for infants and children.

"Your cooperation throughout the campaign has been excellent. May I count on you to continue the fight against polio?"

What To Write For

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

What Is an Ophthalmologist? Defines clearly difference in training and functions of an ophthalmologist, optician and optometrist. Physicians may obtain this four-page pamphlet for distribution to their patients. Write The Medical Foundation for Eye Care, 250 West 57th Street, New York 19, N. Y.

* * *

Diabetes Can Cause Blindness. One of many pamphlets written by professional men for lay readers and covering many subjects pertaining to eye care and eye diseases. Individuals and organizations may obtain copies. Write Philadelphia Association for the Blind, 100 East Price Street, Philadelphia 44, Pa. Attn: Prevention of Blindness Department.

* * *

What You Should Know about Asian Flu. This concise folder on this subject informs lay persons of factors concerning the flu, both in prevention and in epidemic. Available in supply for physicians' offices. Write Ohio Department of Health, State Office Building, Columbus, Ohio.

* * *

Adoption in Ohio: A Statement of Policies and Laws. Condensation of Ohio adoption laws prepared by Children's Services, Division of Social Administration, Ohio Department of Public Welfare. Also contains division's policies. Write Ohio State Medical Association, 79 E. State St., Columbus 15, Ohio.

The 57th annual meeting of the Medical Library Association will be held in Rochester, Minn., from June 2 through June 6, 1958, with headquarters in the Hotel Kahler. The Theme of the meeting will be "Advances in Medical Library Practice."

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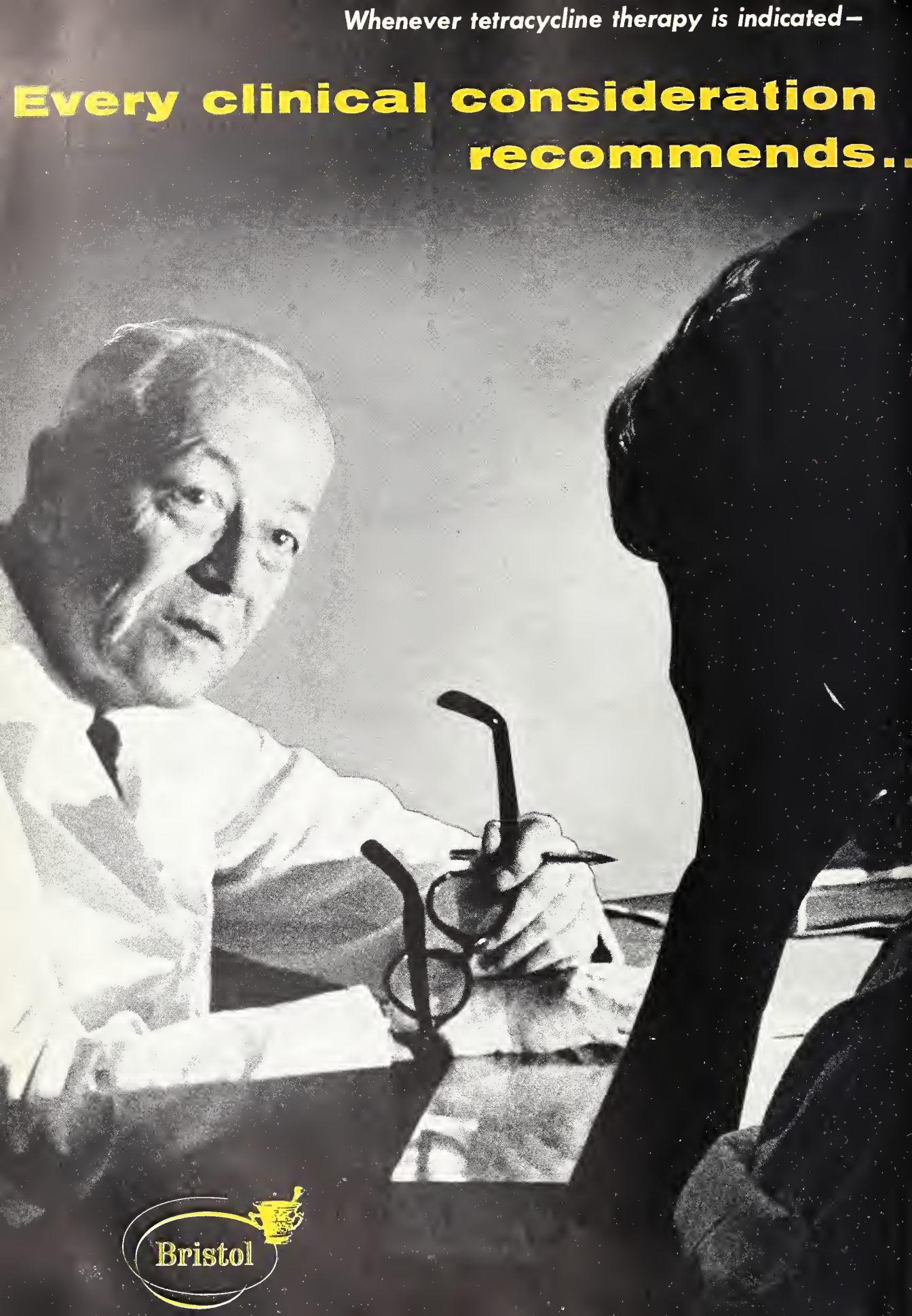
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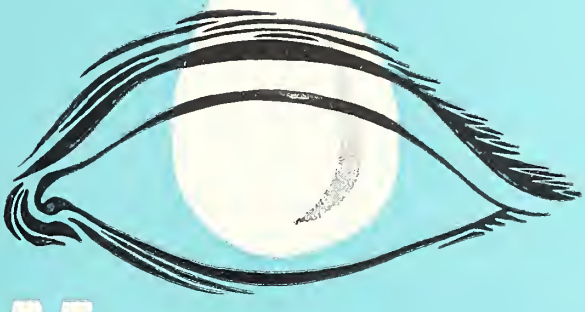
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THE OHIO STATE MEDICAL JOURNAL

INDEX TO VOLUME 53 — 1957

January	Pages	1 to 128
February	"	129 to 252
March	"	253 to 372
April	"	373 to 504
May	"	505 to 620
June	"	621 to 740
July	"	741 to 868
August	"	869 to 980
September	"	981 to 1100
October	"	1101 to 1228
November	"	1229 to 1372
December	"	1373 to 1516

CLINICAL PAPERS

Acne Vulgaris, A New Concept in the Treatment of, (N^1 Sulfanilylacetamide) (A. Harvey Neidorff) 293

Adhesions, Postoperative, The Problem of Recurrent (Ward Meyers) 661

Agranulocytosis Due to Chlorpromazine (Morton Rosenthal and Angeline E. O'Donnell) 1424

Airway Problem, an Acute, in the Newborn, The Pierre-Robin Syndrome: (John C. Trabue and Bruce C. Martin) 1016

Alcoholic, The, in Group Psychotherapy with Psychotic Patients (Burman H. Preston) 656

Aneurysm, Arteriovenous, of the Ovarian Artery and Vein—A Case Report (Leonard Gottesman, Lawrence J. Wilchins, and Nathan Aronoff) 1428

Aneurysm, False, of the Facial Artery: Case Report and Review of Literature (J. W. Sampsel and C. W. Holcomb) 1148

Aneurysm, Long-Standing, of the Thoracic Aorta, Unusual Case of (Jack T. Collins and Salvatore M. Sancetta) 780

Antiarthritic Agent, An Evaluation of Phenylbutazone as an (James Vollmer, Richard Weiskittel and Joseph L. DeCourcy) 910

Antibiotics, Bacterial Resistance to, An Unusual Case of, with Successful Reversal by Use of Isonicotinic Acid Hydrazide and Para-Aminosalicylic Acid (Walter L. George and Steven Zsako) 1023

Antitussive Drugs, Non-Narcotic, A Comparative Study of Two New (S. William Simon) 1426

Aorta, the Thoracic, Unusual Case of Long-Standing Aneurysm of (Jack T. Collins and Salvatore M. Sancetta) 780

Arterial Grafting, Major, The Present Status of (Alfred W. Humphries, Victor G. deWolfe, and Fay A. LeFevre) 1413

Artery, Facial, False Aneurysm of the: Case Report and Review of Literature (J. W. Sampsel and C. W. Holcomb) 1148

Arthritis, Rheumatoid; Chronic Cardiac Compression (Constrictive Pericarditis and, A Case Report: Unusual Association of Two Diseases in the Same Patient (Frank H. Healey and Herschel E. Mozen) 1146

Arthritis, Rheumatoid, Diffuse Interstitial Fibrosis Complicating (Report of a Case) (Warren W. Smith and Norman O. Rothermich) 773

Asthmatic Patient, the, A New Formula for Continuous Medication in (Hermann Blatt) 1028

Bendectin® in the Treatment of Nausea of Pregnancy (Ray O. Nulsen) 665

Blood Sugar, Fasting, Alone in Diabetes Therapy, Information and Misinformation Gained from (Henry J. John) 1284

Burns, Major, Management of Patients with,—An Outline for the Hospital Staff (John R. Brown, P. A. Weisman, and G. G. Ediss) 37

Carcinoma of Pancreas (Clinicopathological Conference) 424, 922

Carcinoma of Ureter (Clinicopathological Conference) 791

Cardiac Compression, Chronic, (Constrictive Pericarditis) and Rheumatoid Arthritis; A Case Report: Unusual Association of Two Diseases in the Same Patient (Frank H. Healey and Herschel E. Mozen) 1146

Childhood, Perineal Trauma Especially in, Some Considerations on the Management of (C. Marshall Lee, Jr., Helmut Mattheis, and B. N. Carter II) 287

Chlorpromazine, Agranulocytosis Due to (Morton Rosenthal and Angeline E. O'Donnell) 1424

Choroid, Retina and (William H. Havener) 290

Clinicopathological Conference:

- Cor Pulmonale with Failure 58, 1434
- Diverticulitis of Colon 186
- Rheumatic Heart 301
- Carcinoma of Pancreas 424, 922
- Diffuse Collagen Disease 673
- Carcinoma of the Ureter 791
- Subacute Bacterial Endocarditis 1032
- Diabetes Mellitus 1161
- Bilateral Internal Hydrocephalus 1302

Coffee and Obesity (Leo B. Janis) 659

Columbus State School, The, One Hundred Years of Progress of, Part I, and Part II (Wendell A. Butcher and Mary Knoche) 678, 796

Community Detection of Diabetes (Earl E. Long and George James) 1280

Community Undertaking, School Health Is a (Thomas Shaffer) 541

Complement Fixation Tests, Treponema Pallidum, Comparison of Treponema Pallidum Immobilization and (L. F. Ey, Cal C. Kersell, and Arthur H. Bauer) 653

Congestive Failure, the Elderly Patient in, Overenthusiasm in the Treatment of (M. H. Rosenblum) 777

Coombs Test, The (Ohio Society of Pathologists) 556

Cor Pulmonale with Failure (Clinicopathological Conference) 58, 1434

Crotonyl-N-Ethyl-O-Toluidine, Eurax®, Clinical Evaluation of a Combination of Hydrocortisone and, for Topical Therapy (Arthur J. Tronstein) 1155

Deafness, Surgical Correction of (William H. Saunders) 915

Dermatitis, Poison Ivy, Metisteroid Therapy of (Leon Goldman, and Robert Preston) 285

Diabetes and Tuberculosis (W. L. Wallbank) 920

Diabetes, Community Detection of (Earl E. Long, and George James) 1280

Diabetes Complicated by Pregnancy (See Diabetics, Pregnant)

Diabetes Insipidus Associated with Schizophrenia: Remission Following Electroshock Therapy. (Report of a Case) (Beatrice Postle) 1292

Diabetes Insipidus, Pitressin® Toxicity in, and the Therapeutic Superiority of the Nasal Route for Replacement Therapy. Report of a Case (Warren W. Smith) 1277

Diabetes, Management of, with Tolbutamide (Orinase®) (Richard L. Fulton, and George E. Bell) 1288

Diabetes Mellitus. (Clinicopathological Conference) 1161

Diabetes Therapy, Fasting Blood Sugar Alone in, Information and Misinformation Gained from (Henry J. John) 1284

Diabetics, Pregnant, Management of,—A Ten Year Survey of the Results of Diabetes Complicated by Pregnancy, in Two Private General Hospitals—53 Cases (Robert P. Koenig) 1297

Disease, Collagen, Diffuse (Clinicopathological Conference) 673

Diverticulitis of Colon (Clinicopathological Conference) 186

Dream Interpretation, Freudian, Two Thousand Years Before Freud, Historical and Other Aspects of, Part I, and Part II (Max Serog) 306, 429

Drug Therapy in Tuberculosis (Harold I. Humphrey) 299

Drug Therapy of Hypertension—A Report of a New Agent, Ecolid® (Bernard H. Marks, Paul Radetsky, and D. J. Vincent) 409

Drugs, Antitussive, Two New Non-Narcotic, A Comparative Study of (S. William Simon) 1426

Ecolid®, A Report of a New Agent—Drug Therapy of Hypertension (Bernard H. Marks, Paul Radetsky, and D. J. Vincent) 409

Effusion, Pleural, Primary (John A. Prior) 1030

Endocarditis, Acute Streptococcus Viridans, Vancomycin Treatment in a Case of (Robert P. Koenig) 1141

Endocarditis, Bacterial, Subacute (Clinicopathological Conference) 1032

Epileptics, Psychomotor, Treatment of, with Reserpine (Carl M. Rosenberg) 405

Eurax®, (Crotonyl-N-Ethyl-O-Toluidine), Clinical Evaluation of a Combination of Hydrocortisone and, for Topical Therapy (Arthur J. Tronstein) 1155

Fever, Rheumatic, Acute, Upper Respiratory Infections, Antimicrobial Agents and (David H. Greegor) 1421

Fibrosis, Interstitial, Diffuse, Complicating Rheumatoid Arthritis—Report of a Case (Warren W. Smith, and Norman O. Rothermich) 773

Fluorohydrocortisone, Nystatin and, Ointment, Clinical Observations with a (Roy L. Kile) 47

Formula, A New, for Continuous Medication in the Asthmatic Patient (Hermann Blatt) 1028

Freud, Two Thousand Years Before, Freudian Dream Interpretation,—Historical and Other Aspects of Dream Interpretation, Part I, and Part II (Max Serog) 306, 429

Goiter, Intratracheal (Marvin S. Freeman) 1416

Grafting, Arterial, Major, The Present Status of (Alfred W. Humphries, Victor G. deWolfe, and Fay A. LeFevre) 1413

Health Department, Local, Maternal Mortality and the Role of the (Anthony Ruppersberg, Jr.) 51

Health, School, is a Community Undertaking (Thomas E. Shaffer) 541

Heart, Rheumatic (Clinicopathological Conference) 301

Hemiplegics, Clinical Notes on a Series of (Harry W. Slade) 550

Hesper-C Therapy, Clinical Evaluation of (A. P. R. James) 413

Hospital Transports with Special Reference to the Steamboat *Allen Collier* and the Cincinnati Branch of the U. S. Sanitary Commission, Part I, and Part II (Robert H. Preston) 1037, 1165

Hydrocephalus, Bilateral Internal (Clinicopathological Conference) 1302

Hydrocortisone, A Combination of, and Crotonyl-N-Ethyl-O-Toluidine (Eurax®, for Topical Therapy (Arthur J. Tronstein) 1155

Hypertension, Drug Therapy of—A Report of a New Agent, Ecolid® (Bernard H. Marks, Paul Radetsky, and D. J. Vincent) 409

Hypertension, Portal, The Treatment of (John Storer) 416

Infarction, Myocardial, Silent—A Case Report with a Brief Review of Literature (M. P. Sambhi, and Henry A. Zimmerman) 537

Infections, Upper Respiratory, Antimicrobial Agents and Acute Rheumatic Fever (David H. Greegor) 1421

Infections, Virus, Coxsackie and ECHO, in Ohio During 1956 (D. M. McLean, C. C. Croft, J. T. Prince, and Edna Heckmann) 907

Isonicotinic Acid Hydrazide and Para-Aminosalicylic Acid, An Unusual Case of Bacterial Resistance to Antibiotics with Successful Reversal by Use of (Walter L. George, and Steven Zsako) 1023

Laboratory Procedures, Current:

The Serum Transaminase Assay 295

Plasma Prothrombin, Serum Prothrombin and Thromboplastin Generation Tests; Aids in Study of Defects in Coagulation (No. 1) 423

The Coombs Test 556

The Thromboplastin Generation Test; Aids in the Study of Coagulation Defects (No. 2) 667

Maternal Health in Ohio—Maternal Mortality Studies on:

Cerebral Hemorrhage 55

Intra-abdominal Hemorrhage 184

Pulmonary Emboli 296

Amniotic Fluid Embolism 419

Cardiac Disease 553

(Alleged) Criminal Abortion 671

Afibrinogenemia 788

Hemorrhage 1020

Infection 1159

Diabetes 1295

Toxemia 1431

Maternal Mortality and the Role of the Local Health Department in the Prevention of These Deaths (Anthony Ruppersberg, Jr.) 51

Medical College Psychiatric Lamplighter, Samuel Mitchel Smith, M. D., Part I, and Part II (Philip C. Rond) 1266, 1405

Medical College, Starling, Meetings of the Faculty of, in 1859 (Jonathan Forman) 926

Medical Heritage, Ohio's, (The President's Address) (Richard L. Meiling) 799

Metisteroid Therapy of Poison Ivy Dermatitis (Leon Goldman, and Robert Preston) 285

Multiple Sclerosis, Studies on the Etiology and Specific Treatment of (Edward C. Rosenow) 783

Myocardial Infarction, Silent,—A Case Report with Brief Review of Literature (M. P. Sambhi, and Henry A. Zimmerman) 537

Nausea of Pregnancy, Bendectin® in the Treatment of (Ray O. Nulsen) 665

Newborn, An Acute Airway Problem in the, The Pierre-Robin Syndrome (John C. Trabue, and Bruce C. Martin) 1016

N[1] Sulfanilylacetamide, A New Concept in the Treatment of Acne Vulgaris (A. Harvey Neidorff) 293

Nystatin and Fluorohydrocortisone Ointment, Clinical Observations with a (Roy L. Kile) 47

Obesity, Coffee and (Leo B. Janis) 659

Ohio's Medical Heritage (The President's Address) (Richard L. Meiling) 799

Ohio State School, The, One Hundred Years Old (Jonathan Forman) 561

Ointment, Nystatin and Fluorohydrocortisone, Clinical Observations with a (Roy L. Kile) 47

One Hundred Years of Progress of The Columbus State School, Part 1, and Part II (Wendell A. Butcher, and Mary Knoche) 678, 796

One Hundred Years Old, The Ohio State School (Jonathan Forman) 561

Optic Chiasm, A Case Report of Metastatic Tumor—Value of the Midline Planigram for Diagnosis of a Midline Brain Tumor (Bert H. McBride, and Edward C. Elsey) 545

(Orinase®) Tolbutamide, Management of Diabetes with (Richard L. Fulton, and George E. Bell) 1288

Pancreas, Carcinoma of (Clinicopathological Conference) 424, 922

Para-Aminosalicylic Acid, An Unusual Case of Bacterial Resistance to Antibiotics with Successful Reversal by Use of Isonicotinic Acid Hydrazide and (Walter L. George, and Steven Zsako) 1023

Pathologists, the Ohio Society of (See Clinicopathological Conference)

Pathologists, the Ohio Society of (See Laboratory Procedures, Current)

Pathologists, the Ohio Society of, Proceedings of Fall Meeting Held September 22, 1956 557

Patient, the Asthmatic, A New Formula for Continuous Medication in (Hermann Blatt) 1028

Patient, Elderly, in Congestive Failure, Overenthusiasm in the Treatment of M. H. Rosenblum) 777

Patient, Tuberculous, The Recalcitrant (H. J. Nimitz) 669

Patients, Psychotic, The Alcoholic in Group Psychotherapy with (Burman H. Preston) 656

Patients with Major Burns, Managements of—An Outline for the Hospital Staff. (John R. Brown, P. A. Weisman, and G. G. Ediss) 37

Pericarditis, Constrictive, Chronic Cardiac Compression and Rheumatoid Arthritis; A Case Report: Unusual Association of Two Diseases in the Same Patient (Frank H. Healey, and Herschel E. Mozen) 1146

Perineal Trauma, Especially in Childhood, Some Considerations on the Management of (C. Marshall Lee, Jr., Helmut Mattheis, and B. N. Carter II) 287

Phenylbutazone as an Antiarthritic Agent, An Evaluation of (James Vollmer, Richard Weiskittel, and Joseph L. DeCourcy) 910

Pitressin® Toxicity in Diabetes Insipidus, and the Therapeutic Superiority of the Nasal Route for Replacement Therapy. Report of a Case. (Warren W. Smith) 1277

Planigram, Midline, Value of the, for Diagnosis of a Midline Brain Tumor—A Case Report of Metastatic Tumor, Optic Chiasm. (Bert H. McBride, and Edward C. Elsey) 545

Plasma Prothrombin, Serum Prothrombin and Thromboplastin Generation Tests: Aids in Study of Defects in Coagulation (No. 1) (Ohio Society of Pathologists) 423

Pleural Effusion, Primary (John A. Prior) 1030

Poison Ivy Dermatitis, Metisteroid Therapy of (Leon Goldman, and Robert Preston) 285

Prednisolone, A Comparative Study in 350 Cases with Clinical Evaluation of Newer Anti-Inflammatory Steroids, II (M. M. Szucs, Samuel Petraglia, and M. C. Galose) 1418

Prednisolone TBA, Local Injection of, in the Treatment of Rheumatic Diseases (Norman O. Rothermich and Vol K. Phillips) 45

Pregnancy, Nausea of, Bendectin® in the Treatment of (Ray O. Nulsen) 665

Pregnancy, Tuberculosis and (David T. Kaung) 786

Psychiatric Lamplighter, Medical College, Samuel Mitchel Smith, M. D., Part I, and Part II (Philip C. Rond) 1266, 1405

Psychoneurosis, Social Factors in (Robert M. Frumkin) 415

Psychotherapy, Group, with Psychotic Patients, The Alcoholic in (Burman H. Preston) 656

Pulmonary Tuberculosis, The Present Status of Bed Rest in (William Habeeb) 422

Pulmonary Tuberculosis, The Prognosis of (H. G. Curtis) 1144

Pulmonary Tuberculosis, Surgery in (Elmer R. Mauer) 548

Receiving Hospitals in Ohio, The Status and Progress of (Eugene E. Elder) 49

Rehabilitation, Psychological Aspects of (Alexander P. Orfirer) 281

Reserpine, Treatment of Psychomotor Epileptics with (Carl M. Rosenberg) 405

Retina and Choroid (William H. Havener) 290

Rheumatic Diseases, Local Injections of Prednisolone TBA in the Treatment of (Norman O. Rothermich and Vol K. Philips) 45

Rheumatic Fever, Acute, Upper Respiratory Infections, Antimicrobial Agents and (David H. Greegor) 1421

Rheumatic Heart (Clinicopathological Conference) 301

Rheumatoid Arthritis, Diffuse Interstitial Fibrosis Complicating (Report of a Case) (Warren W. Smith and Norman O. Rothermich) 773

Serum Transaminase Assay, The (Ohio Society of Pathologists) 295

Schizophrenia, Diabetes Associated with: Remission Following Electroshock Therapy (Report of a Case) (Beatrice Postle) 1292

School Health is a Community Undertaking (Thomas E. Shaffer) 541

Sclerosis, Multiple, Studies on the Etiology and Specific Treatment of (Edward C. Rosenow) 783

Sigmoid, Volvulus of the (Grant A. Leiby, Jr., Simon Spendiarian, and F. A. Simeone) 1018

Smith, Samuel Mitchel, M. D., Medical College Psychiatric Lamplighter, Part I, and Part II (Philip C. Rond) 1266, 1405

Social Factors in Psychoneurosis (Robert M. Frumkin) 415

Starling Medical College, Meetings of the Faculty of, in 1859 (Jonathan Forman) 926

State School, The Columbus, One Hundred Years of Progress of, Part I, and Part II (Wendell A. Butcher, and Mary Knoche) 678, 796

State School, The Ohio, One Hundred Years Old (Jonathan Forman) 561

Steroids, Newer Anti-Inflammatory, Clinical Evaluation of, II,—A Comparative Study in 350 Cases with Prednisolone (M. M. Szucs, Samuel Petraglia, and M. C. Galose) 1418

Streptococcus Viridans Endocarditis, Acute, Vancomycin Treatment in a Case of (Robert P. Koenig) 1141

Syndrome, The Pierre-Robin: An Acute Airway Problem in the Newborn (John C. Trabue, and Bruce C. Martin) 1016

Test, The Tuberculin (Robert J. Atwell) 1429

Tetanus Prophylaxis, Outline of Emergency Room Care of Wounds and (LeRoy Jay Hyman) 1013

Thromboplastin Generation Test; Aids in the Study of Coagulation Defects (No. 2) (Ohio Society of Pathologists) 667

Tolbutamide (Orinase®), Management of Diabetes with (Richard L. Fulton, and George E. Bell) 1288

Toxicity, Pitressin,® in Diabetes Insipidus, and the Therapeutic Superiority of the Nasal Route for Replacement Therapy. Report of a Case (Warren W. Smith) 1277

Trauma, Perineal, Especially in Childhood, Some Considerations on the Management of (Marshall Lee, Jr., Helmut Mattheis, and B. N. Carter II) 287

Treponema Pallidum Immobilization and Treponema Fixation Tests (L. F. Ey, Cal C. Kersell, and Arthur H. Bauer) 653

Trichobezoar: Survival Following Complication of Perforated Ulcer (James E. Mullen) 41

Tuberculin Test, The (Robert J. Atwell) 1429

Tuberculosis and Pregnancy (David T. Kaung) 786

Tuberculosis, Diabetes and (W. L. Wallbank) 920

Tuberculosis, Drug Therapy in (Harold I. Humphrey) 299

Tuberculosis, Pulmonary, The Present Status of Bed Rest in (William J. Habeeb) 422

Tuberculosis, Pulmonary, The Progress of (H. G. Curtis) 1144

Tuberculosis, Pulmonary, Surgery in (Elmer R. Mauer) 548

Tuberculous Patient, The Recalcitrant (H. J. Nimitz) 669

Tumor, Brain, Midline, Value of the Midline Planigram for Diagnosis of a (A Case Report of Metastatic Tumor, Optic Chiasm) (Bert H. McBride, and Edward C. Elsey) 545

Vancomycin Treatment in a Case of Acute Streptococcus Viridans Endocarditis (Robert P. Koenig) 1141

Venereal Diseases, Are the, Really Conquered? (Hugo Hecht) 901

Virus, Coxsackie and ECHO, Infections in Ohio During 1956 (D. M. McLean, C. C. Croft, J. T. Prince, and Edna E. Heckmann) 907

Volvulus of the Sigmoid (Grant A. Leiby, Jr., Simon Spendiarian, and F. A. Simeone) 1018

Wounds, Outline of Emergency Room Care of, and Tetanus Prophylaxis (LeRoy Jay Hyman) 1013

AUTHORS OF CLINICAL PAPERS AND CASE RECORDS

Aronoff, Nathan (Cincinnati) 1428
Atwell, Robert J. (Columbus) 1429
Bauer, Arthur H. (Columbus) 653
Bell, George E. (Columbus) 1288
Blatt, Hermann (Cincinnati) 1028
Brown, John R. (Dayton) 37
Burkons, Harold F. (Cleveland) 1151
Butcher, Wendell A. (Columbus) 678, 796
Carter, B. N. H (Cincinnati) 287
Collins, Jack T. (Cleveland) 780
Croft, C. C. (Columbus) 907
Curtis, Harold G. (Cleveland) 1144
DeCourcy, J. L. (Cincinnati) 910
deWolfe, Victor G. (Cleveland) 1413
Ediss, G. G. (Dayton) 37
Elder, Eugene E. (Youngstown) 49
Elsey, Edward C. (Cincinnati) 545
Ey, Leo F. (Columbus) 653
Forman, Jonathan (Columbus) 561, 926
Freeman, Marvin S. (Cleveland) 1416
Frumkin, Robert M. (Buffalo, N. Y.) 415
Fulton, Richard L. (Columbus) 1288
Galose, M. C. (Youngstown) 1418
George, Walter L. (Cleveland) 1023
Goldman, Leon (Cincinnati) 285
Greegor, David H. (Columbus) 1421
Gottesman, Leonard (Cincinnati) 1428
Habeeb, William J. (Springfield) 422
Havener, William H. (Columbus) 290
Healey, Frank H. (Salem, Mass.) 1146
Hecht, Hugo (Cleveland) 901
Heckmann, Edna E. (Reynoldsburg) 907
Holcomb, C. W. (Richwood) 1148
Holzaepfel, John H. (Columbus) 50, 183, 298, 421, 547, 790, 921, 1022, 1164, 1296
Humphrey, Harold I. (Columbus) 299
Humphries, Alfred W. (Cleveland) 1413
Hyman, LeRoy Jay (Cleveland) 1013
James, Arthur P. R. (Toledo) 413
James, George (Akron) 1280
Janis, Leo B. (Toledo) 659
John, Henry J. (Cleveland) 1284
Jolly, Paul N. (Cincinnati) 557
Kaung, David T. (Cleveland) 786
Kersell, Cal C. (Columbus) 653
Kile, Roy L. (Cincinnati) 47
Knoche, Mary (Columbus) 678, 796
Koenig, Robert P. (Cincinnati) 1141, 1297
Lee, C. Marshall, Jr. (Cincinnati) 287
Le Fever, Fay A. (Cleveland) 1413
Leiby, Grant A. (Cleveland) 1081
Long, Earl E. (Akron) 1289
Marks, Bernard H. (Columbus) 409
Martin, Bruce C. (Columbus) 1016
Mattheis, Helmut (Cincinnati) 287
Maurer, Elmer R. (Cincinnati) 548
McBride, Bert H. (Cincinnati) 545
McLean, D. M. (Melbourne, N. 2 Australia) 907
Meiling, Richard L. (Columbus) 799
Meyers, Ward (Toledo) 661
Mozen, Herschel E. (Cleveland) 1146
Mullen, James E. (Toledo) 41
Neidorff, A. Harvey (Altoona, Pa.) 293
Nimitz, H. J. (Cincinnati) 669
Nulsen, Ray O. (Cincinnati) 665
O'Donnell, Angeline E. (Cleveland) 1424
Orfirer, Alexander P. (Cleveland) 281
Petraglia, Samuel (Youngstown) 1418
Philips, Vol K. (Columbus) 45
Postle, Beatrice (Athens) 1292
Preston, Burman H. (Cincinnati) 656
Preston, Robert H. (Cincinnati) 285, 1037, 1165
Prince, J. T. (Minneapolis, Minn.) 907
Prior, John A. (Columbus) 1030
Radetsky, Paul (Columbus) 409
Rond, Philip C. (Columbus) 1266, 1305
Rosenberg, Carl M. (Columbus) 405
Rosenblum, M. H. (Steubenville) 777
Rosenow, Edward C. (Minneapolis, Minn.) 783
Rosenthal, Morton (Cleveland) 1424
Rothermich, Norman O. (Columbus) 45, 773
Ruppersberg, Anthony, Jr. (Columbus) 51
Sambhi, M. P. (Cleveland) 537
Sampsel, J. W. (Marysville) 1148
Sancetta, Salvatore M. (Cleveland) 780
Saunders, William H. (Columbus) 915
Serog, Max (Dayton) 306, 429
Shaffer, Thomas E. (Columbus) 541
Simeone, F. A. (Cleveland) 1018
Simon, S. William (Dayton) 1426
Slade, Harry W. (Waco, Texas) 550
Smith, Warren W. (Columbus) 773, 1277
Spendiarian, Simon (Cleveland) 1018
Storer, John (Cleveland) 416
Szucs, M. M. (Youngstown) 1418
Trabue, John C. (Columbus) 1016
Tronstein, Arthur J. (Newark) 1155
Vincent, D. J. (Columbus) 409
Vollmer, James E. (Cincinnati) 910
Wallbank, W. L. (Toledo) 920
Weiskittel, Richard (Cincinnati) 910
Weisman, Philip A. (Dayton) 37
Wilchins, Lawrence J. (Cincinnati) 1428
Zimmerman, Henry A. (Cleveland) 547
Zsako, Steven (Cleveland) 1023

GENERAL INDEX

Accreditation, Joint Commission on—
Joint Commission Modified Standards, 606; Principles of Hospital Accreditation, Functions and Structure of the Joint Commission, 928; Hospital Accreditation Commission Has Complied with Most of the Recommendations of the AMA Stover Committee, 1039; Hospital Staff Meetings, 1174; Joint Commission Will Survey Mental Institutions on Request, 1175; Fully Accredited Hospitals Will Be Sent Pamphlets, 1180; Medical Records, 1307; Responsibilities of Medical Staff, ... 1444

Advertisers, Index to—114, 242, 354, 490, 606, 718, 866, 978, 1080, 1212, 1354, ... 1514

Advertising, Classified—115, 243, 355, 491, 607, 719, 867, 979, 1081, 1213, 1355, ... 1515

Adoptions—
The Doctor and Adoptions, ... 1452

Aged, Aid for—
Division of Aid for Aged Adopts New Radiation Therapy Schedule, 464; Deadline Set on Health Care Claims under Aid for Aged, 577; Medical Fee Schedule of Division of Aid for the Aged Slashed, 846; State Association Council Will Confer with Division of Aid for the Aged, 948; Letter Sent to the Governor in Regard to AFA Health Care Problem, 1181; Developments in AFA Program, ... 1320

Aging—(See Geriatrics)

American Medical Association—
Report of the AMA Session (Nov. 27-30, 1956), 65; A Choice To Make—Address of Pres. Murray, 83; Medical Education Week, 86; New Patient Information Card Helps Efficiency, 94; Standard Nomenclature of Diseases, 98; Drama of Surgery in Transcription, 115; AMA Has Information on Home Care, 196; You and Your AMA, 334; AMA Field Director Is Appointed, 334; Uniform Labeling Study Launched by AMA, 354; AMA Meeting in New York (Preview), 438; AMA Sex Pamphlets Now in Book Form, 459; Tours Are Being Arranged After AMA Meeting, 491; Dr. Lincke Represents AMA Before London Medical Congress, 712; Film Tells Public What AMA Does, 808; Doctors as Diplomats To Be Shown in New TV Film, 827; New Mental Health Film Available, 827; Cleveland Facilities Not Adequate for June AMA Meeting, 861; Role of Radiologist on Film, 946; Name Is New (Council on Drugs) but Same Valuable Service, 954; Lull Named Assistant to AMA President; Blasingame Will Become General Manager, 1062; You and Your AMA, 1066; Several Ohioans Honored by Posts in Specialty Sections of AMA, 1171; Should Be a Member Regardless of Status, 1192; AMA Revamps Today's Health Publication Set-Up, 1194; You and Your AMA, 1194, 1245, 1394; New Directory Scheduled, 1465; Observations on Inside Russia Related by AMA President, ... 1475

American Medical Education Foundation—
More than $4-Million Goes to Medical Schools from AMEF and NFME, 353; Largest Gift to University of Cincinnati Is From AMEF Fund, 577; Woman's Auxiliary Contributes to AMEF, 837; Time To Give To AMEF; Appointment of Committeemen, 1170; Now Is Time To Give to AMEF, ... 1329

Annual Meeting—
New Setting and New Features for the 1957 Meeting, 71; One Graphic Illustration Is Worth 10,000 Words, 205; Annual Meeting Guest Speakers, 309; Resolutions Should Be Sent to Columbus Office Now, 312; Announcing the Official Program for the 1957 Annual Meeting, 439; Meetings of Specialty Societies and Health Groups, 454; Will Entertain Members, 568; Resumé of the 1957 Annual Meeting Program, 569; Results of Election Announced, 691; Ohio's Medical Heritage—The President's Address, 799; Presenting the President-Elect and One New Councilor, with Information about Other Members of The Council, 806; Annual Meeting in Review, 809; House of Delegates Proceedings, 810; Correction in Proceedings of House, 958; House of Delegates Roll Call, 826; Annual Meeting Attendance, 828; Members Who Attended, 829; Hotel Reservation Page, 1324; Annual Meeting Program Schedule, 1325; Application for Space in 1958 Scientific Exhibit, 1327; Invitation for Entries, 1448; Application for Exhibit Space, 1449; Hotel Reservation Page, ... 1450

Apparatus—(See under Pharmaceuticals)

Associations, Societies and Organizations—
American College of Surgeons Offers Fracture Course, 196; Lithuanian-American Doctors Organize Ohio Society, 212; Phi Delta Epsilon at OSU, 214; Northern Tri-State Medical Association Schedules Program, 320; Central Region, American College of Gastroenterology Meeting, 323; Early 1957 Health Forum Program Scheduled in Cincinnati, 326; Ohio Medical Assistants Plan Get-Together, 354; World Congress on Gastroenterology, 437; Ohio State Surgical Society and Columbus Surgical Society Program, 454; Ohio Chapter, American Academy of Pediatrics, 455; Ohio Chapter, American College of Chest Physicians, 455; Dr. Homer Smith To Speak for Phi Delta Epsilon, 464; American College of Chest Physicians Program Includes Ohioans, 565; American Board of Obstetrics, 577; State and National Tournaments Hold Promise for Ohio Golfers, 581; Fort Steuben Academy, 583; Ohio State Radiological Society To Meet in Dayton, 589; Two Ohioans Named Trustees of Student AMA Foundation, 600; American Public Health Association Will Meet in Cleveland, 681; Fort Steuben Academy, 688; American College of Gastroenterology Postgraduate Course, 688; UC Physicians Participate in National Pathology Meet, 690; Obstetrics and Gynecology, 705; Dr. Cummer Honored by American Academy of Dermatology, 827; American College of Chest Physicians Names Ohioans as Fellows, 945; Michigan To Hold Annual Meeting, 950; Cleveland Ophthalmological Club Officers, 958; World Congress on Gastroenterology, 964; American College of Surgeons To Meet, 976; Ohio Society of Internal Medicine To Hold Second Meeting, 1175; Cardiac Emergencies Featured by Central Ohio Heart Association, 1210; Several Ohioans Will Participate in Bahamas Conference, 1309; Fort Steuben Academy Program, 1326; Cincinnati Will Be Host to Midwest Conference on Rheumatic Diseases, ... 1485

Attorney General, Legal Opinions—
Guardianship of Delinquent Children, 338; Financing Mental Health Clinics, 338; Area Jurisdiction of Boards of Health, 339; Status of Mental Patients, 339; Use of Proceeds from Bond Issue on Hospital, 688; Registration of Water Well Drillers, 1465; Reregistration of Nurses, 1465; Superintendent of TB Hospital and Charging of Fees, ... 1465

Audit, Annual of OSMA Books 584

Blood—
Survey of Blood Banks, ... 1195

Blue Cross; Blue Shield—(See under Prepaid Medical and Hospital Insurance, and Ohio Medical Indemnity)

Board Certification—
Ohio Physicians Are Certified in Obstetrics and Gynecology, ... 1171

Book Reviews—(See Physician's Bookshelf)

Cancer—
Franklin County Pelvic Cancer Delay Committee Report, 50, 183, 298, 421, 547, 790, 921, 1022, 1164, ... 1296
Hoxsey Cancer Treatment Declared a Fraud by Another Court, 95; Columbus Cancer Survey Progressing Well, 475; Dr. H. S. Diehl, Named to Post with American Cancer Society, ... 1213

Civic and Governmental Affairs—
Send Your Ideas on Expense Cuts to Bricker, Lausche, 578; Let's Correct Ohio's Poor Election Day Showing, 578; Jenkins-Keogh Drive Started, 696; Plenty of Talk but Chances for Real Changes Dim, 952; Elections Are All-Important Despite So-Called "Off-Year," 1192; Action Back Home Better Than Lobby, 1260; This Investigation Could Accomplish Much, 1260; Young GOP Takes a Look at U. S. Health Picture, ... 1402

Civil Defense—
Recent CD Publications, 979, ... 1064

Coming Meetings—243, 354, 490, 606, 978, 1080, ... 1354

Conference of County Society Officers and Committeemen—
Conference Scheduled February 24—Program, 206; Report of Conference, ... 574

Corporate Practice—
Iowa Settlement—Agreement Between Physicians and Hospitals, ... 955

Council, The—
Proceedings of the December 15-16 Meeting, 192; Rural Health Activities, 197; PR Committee Meets, 200; Proceedings of February 23 Meeting, 432; Proposed By-Laws Amendments Proposed by The Council, 462; Proceedings of April 27 Meeting, 680; Presenting the New President-Elect and One New Councilor with Information about Other Members of The Council, 806; Proceedings of September 14 and 15 Meetings in Granville, ... 1312

County Societies, Activities of—106, 232, 340, 482, 592, 708, 854, 977, 1078, 1206, 1338, ... 1480
Medical Society as Leader of Community's Progress, 94; Sir Edward Appleton To Be Cincinnati Centennial Speaker, 103; Cincinnati Academy Centennial, 216; Columbus Academy and Several of Its Members Cited by Health Council, 224; Good Project—Every Society Should Cooperate, 230; Toledo Acad-

emy Host to Northern Tri-State Medical Association, 320; Medical Organizations Join in Dayton VD Seminar, 337; Subcommittee on Alcoholism of Cleveland Academy Co-sponsors Program, 437; Dayton Seminar on VD Scheduled, 453; Cincinnati Centennial Is Medical Milestone, 470; Toledo Attorneys and Physicians Meet To Discuss Common Interests, 586; Mahoning County Society Handles PR Problem Well, 848; Here's Good Way for County Society To Grade Itself, 954; Columbus Academy Schedules Postgraduate Clinic, 1045; Password to Medical Society Brass Hats, 1403; Cleveland Academy Executive Secretary Resigns, ... 1441

Deaths—102, 226, 330, 478, 588, 702, 852, 966, 1069, 1199, 1334, ... 1474

District Societies—
Ninth District Meeting and Seminar Conducted in Portsmouth, 718; Sixth District Postgraduate Day Set in Canton, 929; Eighth District Postgraduate Program, 1045; Montgomery County Program Will Be Second District Feature, 1046; Sixth District Postgraduate Day, 1046; Northwestern Ohio Medical Association Program, 1047; Eighth District Program at Marietta Well Attended, 1326; Second District Society Elects, 1472; Meeting of Northwestern Ohio Society, ... 1472

Do You Know?—322, 700, 939, 1074, 1336, ... 1469

Economic Factors in Practice—
Nation's Health Dollars—Where They Come From, Where They Go 960

Ethics, Matters of Policy, etc. —
Good Case Records an Excellent Defense, 228; Guides of Conduct Relating to Laboratories, 228; Physician-Lawyer Code, 571; Use of Double Standard of Fees Can Be Dangerous, 578; How Term Clinic Is Used Is Important Factor, 698; Fully Informed, Fairly Treated Patients Rarely Sue, 698; Is It Ethical or Unethical, 952; Separate Bills, Says Judicial Council, 1060; Psychologists and Treatment of Disease, 1058; Medical Professional Liahility; a Report of the AMA Law Department, 1168; Privilege To Set Fee Can Be Ahused, 1190; Ethics and Mailing of Reprints, 1190; Announcements on Opening Office—Ethical or Unethical? 1260, 1403; New Code of Ethics for Hospitals, 1464; What To Tell the Patient, ... 1466

Executive Secretaries—
Executive Secretaries of County Societies Meet for Discussions, ... 1353

Financial Report, OSMA—(See under Audit)

Fifty-Year Physicians—(See under Activities of County Societies)

Food, Drug and Cosmetic Act—
New Act Became Effective Septemher 13, ... 1188

Foreign Medical Graduates—
New Council Begins Its Work, ... 1470

General Practitioners—
American Academy of GP To Meet in St. Louis, 226; ACGP To Hold Assembly in St. Louis, 352; Symposium on Alcoholism for GP's Scheduled in Cleveland, 437; GP's Define the Meaning of "General Practice," 719; Ohio Academy of GP Annual Scientific Assemhly Program, 945; Ohio Academy of General Practice Annual Assemhly Scheduled, 1044; Marriage Counseling Discussed hy Cincinnati Area GP's 1355

Geriatrics—
The Doctor and His Aged Patient, ... 1403

Health and Medical Care—
Nation's Health Dollars—Where They Come From, Where They Go, ... 960

Heart—
Central Ohio Heart Association Program Planned, 74; Law-Medicine Center, Western Reserve, To Present Program on Heart, 315; Annual Meeting, Ohio State Heart Association, 454; Dr. Blalock To Address Central Ohio Heart Association, 586; Scientific Session of American Heart Association Will Honor Harvey, 685; Dr. Eugene B. Ferris, Jr., Named Medical Director of American Heart Association, 705; Ohio Institutions Benefit from Life Insurance Heart Grants, 707; Ohio State Heart Association Elects Officers, 853; Ohioans Are Named to Positions in American Heart Association, ... 1446

Historian's Notebook—
The Medical Men in George Washington's Life, 62, 190; Rare Historical Collection (of Dr. Victor R. Turner, Newark), 64; Freudian Dream Interpretation Two Thousand Years Ago, 306, 429; The Ohio State School One Hundred Years Old, 561; One Hundred Years of Progress of the Columbus State School, 678, 798; Stresses Need for More Medical Historians, 677; Ohio's Medical Heritage, the President's Address, 1957 Annual Meeting, 799; Cincinnati Academy Recounts 100 Years of Progress in Published Volume, 805; Meetings of the Faculty of Starling Medical College in 1859, 926; Hospital Transports (Civil War), Part I, 1037, Part II, 1165; Wisconsin Physicians Plan Medical Museum, 1267; Samuel Mitchel Smith, M. D., Medical College Psychiatric Lamplighter, Part I, 1266; Part II 1405

Hospitals—
Iowa Doctor-Hospital Dispute, 97; Cincinnati Sanitarium Changes Its Name to Emerson A. North Hospital, 312; Joint Commission Modified Standards, 606; Principles of Hospital Accreditation, Functions and Structure of the Joint Commission, 928; Iowa Settlement—Agreement Between Physicians and Hospitals, 955; Hospital Accreditation Commission Has Complied with Most of the Recommendations of the AMA Stover Committee, 1039; Toledo Center Will Be Converted to Children's Hospital, 1171; Hospital Staff Meetings, Report of the Joint Commission, 1174; North Wing Being Added to University Hospital in Columbus, 1212; Kettering Hospital Dedicated in Loudonville, 1329; 132 Per Thousand Admitted to Hospitals, 1441; New Code of Ethics for Hospitals, ... 1464

House of Delegates—
Roster of Delegates and Alternates, 460; Proposed By-Laws Amendments, 462; Resolution for OSMA Meeting, 464; Resolutions Should Be Sent to Columbus Office Now, 483; These Resolutions Will Be Presented to House, 582; Minutes of the 1957 Sessions, 810; Correction in Minutes, 958; Roll Call for 1957 Sessions, ... 826

In Memoriam—(See Deaths)

In Our Opinion—
New Patient Information Card Helps Efficiency, 94; Medical Society as Leader of Community's Progress, 94; Internal Revenue Ruling Appears To Split Hairs, 94; Physicians Can Prevent Improper Use of Drugs, 94; Medical Men Can Help Reduce Highway Deaths, 94; Main Reasons for Suits of Malpractice Listed, 95; Britain's "Dream" Medicine Is More Like a Nightmare, 95; Good Case Records on Excellent Defense, 228; Guides of Conduct Relating to Laboratories, 228; The Clinical Case and Insurance, 228; "Unless Doctors Wake Up"—230; Good Project—Every Society Should Participate, 230; Creeping Socialism in Small Chunks, 324; Try Yelling Now to Your Legislators, 324; Admission Standards Are Re-Examined, 324; Minor of Responsihle Age Can Give Consent, 324; The Doctor and the Press, 325; Cincinnati Centennial Is Medical Milestone, 470; Support Urged for New Section on Industrial Medicine, 470; Some Good Hunches for the Medical Witness, 470; Few Words May Forestall Malpractice Litigation, 470; Medicolegal Aspects of Blood Transfusions, 471; Law Enforcement a Local Responsibility, 578; Send Your Ideas on Expense Cuts to Bricker, Lausche, 578; Use of Douhle Standard of Fees Can Be Dangerous, 578; Let's Correct Ohio's Poor Election Day Showing, 578; Insurance Group Stresses Some Pertinent Facts, 579; No More Hospitals Needed for Service-Connected Cases, 579; Agree U. S. Should Exit from Polio Vaccine Picture, 579; Supports Ohio Stand Against Naturopathy, 579; How Term (Clinic) Is Used Is Important Factor, 698; Fully Informed, Fairly Treated Patients Rarely Sue, 698; Labor Diagnostic Clinic Advised Against Expansion, 698; Wise Approach To Knotty Prohlem (Having Family Physician), 700; No Need To Pay Bonus for Birth Certificate, 848; Mahoning County Society Handles PR Problem Well, 848; "When You Begin Practice" Lectures Appreciated, 848; Rules, Regulations and Controls, 952; Plenty of Talk hut Chances for Real Change (in Government Control) Quite Dim, 952; Is It Ethical or Unethical, 952; Continuous Supervision (of Child Health) Is Most Effective Plan, 952; Better Discuss This with Your Insurance Adviser, 954; Here's Good Way for County Society To Grade Itself, 954; Population Increase Challenges Medicine, 954; Name (Council on Drugs) Is New but Same Valuable Service, 954; Warning to Drug Firms on Distribution of Flu Vaccine, 1058; Preceptorship Program Is Outstanding Success, 1058; Conference on Athletic Injuries, 1058; Psychologists and Treatment of Disease, 1058; Separate Bills, Says Judicial Council, 1060; Ethics and Mailing of Reprints, 1190; New Drug Law a Step Forward, 1190; Don't Count on Fanatics Giving Up, 1190; Privilege To Set Fee Can Be Abused, 1190; Move on for Medical Care in Social Security System, 1190; Elections Are All-Important Despite So-Called "Off-Year," 1192; Should Be a Memher Regardless of Status, 1192; Fitness Idea Should Not Be Overinflated, 1192; Sale of Flu Vaccine Direct to Lay Groups Condemned, 1259; Health Card Program Has Much Merit, 1259; The New School Year and Recruitment of Health Personnel, 1259; This Investigation Could Accomplish Much, 1260; Announcements on Opening Office—Ethical or Unethical? 1260; Action Back Home Better Than Lobby, 1260; Conflict on Wealth and

Welfare, 1402; Young GOP Takes a Look at U. S. Health Picture, 1402; The Press, Medicine and the Public, 1402; Is It Ethical or Unethical, 1403; Don't Leave Narcotics in Your Auto, 1403; What's the Immunization Situation in Your Area? 1403; The Doctor and His Aged Patient, 1403; Password to Medical Society Brass Hats, ... 1403

Industrial Commission of Ohio—(See Workmen's Compensation, Bureau of)

Industrial Health and Medicine—(See also Bureau of Workmen's Compensation)
Support Urged for New Section on Industrial Medicine, 470; Labor Diagnostic Clinic Advised Against Expansion, 698; Industrial Health Program on Fluorides Is Scheduled, 1041; Occupational Health Program, Statement of Procedures and Principles Adopted by AMA House, 1050; Medical Societies Challenged by Union Labor Bigwigs, 1068; Labor Officials Advised, ... 1468

Influenza—
Influenza Situation, 1048; Warning to Drug Firms on Distribution of Flu Vaccine, 1058; Statement of Policy Adopted by OSMA in Regard to Influenza, 1176; Questions and Answers Concerning the Current Influenza, 1178; Sale of Flu Vaccine Direct to Lay Groups Condemned, ... 1259

Insurance—
The Clinical Case and Insurance, 228; Welfare Costs Skyrocket, 336; Insurance Group Stresses Some Pertinent Facts, 579; AMA Compiling Revised Current Health Insurance Data, 825; Nearly $10-Million Daily of Nation's Health Bill Paid by Insurance, 945; Better Discuss This with Your Insurance Adviser, 954; Report New High in Number of Ohioans Protected by Health Insurance, 968; Growth of Health Insurance Coverage, 1193; Health Insurance Protection Still on Increase, 1309; Health Insurance Association Adopts Code of Ethics, ... 1354

Joint Commission on Accreditation of Hospitals—(See Under Accreditation)

Keeping Up With Medicine—40, 169, 294, 408, 549, 664, 785, 1031, 1145, 1301, ... 1417

Labor—(See Under Industrial Health and Medicine)

Laws and Legislation—
Main Reasons for Suits of Malpractice Listed, 95; What Will Congress Do? 208; Ohio Legislature, 213; "Unless Doctors Wake Up," 230; Ohio Congressmen Named to Important Committees, 315; Try Yelling Now to Your Legislators, 324; Minor of Responsible Age Can Give Consent, 324; Ohio Legislation, 468; Law Enforcement a Local Responsibility, 578; Jenkins-Keogh Drive Started, 696; Governor Signs Bill To Make Unclaimed Dogs Available for Medical Research, 845; Legislation—Outstanding Record by General Assembly, 932; Governor Signs H. B. 384, 933; Chief Provisions of House Bill, 384; Iowa Settlement—Agreement Between Physicians and Hospitals Enacted into Law, 955; Drivers Licenses for Epileptics—New Law Goes into Effect, 1065; Barhorst Convicted and Fined on Illegal Practice Charge, 1068; New Food, Drug and Cosmetic Act, 1188; New Drug Law a Step Forward, 1190; Bills Before Congress, 1330; Jenkins-Keogh Proposals Will Be Published, 1333; The Doctor and Adoption, ... 1452

Legal Medicine—
Law-Medicine Center, Western Reserve, To Present Program on Heart, 315; Some Good Hunches for the Medical Witness, 470; Mediocolegal Aspects of Blood Transfusions, 470; Physician-Lawyer Code, 571; Course in Radiation for Doctors and Lawyers Scheduled at UC, 712; Radiation for Industrial Physicians and Lawyers at UC, 965; Medical Professional Liability—a Report of AMA Legal Department, ... 1168

Liability—
Medical Professional Liability—a Report of the AMA Legal Department, ... 1168

Licensure—(See also under State Medical Board)
Foreign Medical Graduates, New Council Begins Work, ... 1470

Maternal Health—
Maternal Mortality and Role of Local Health Departments, 51; Maternal Health in Ohio, 55, 184, 296, 419, 553, 671, 788, 1020, 1295, ... 1431
Principles of Obstetric Care—Recommendations Compiled by Committee on Maternal Health, ... 1328

Medical Education—
Medical Education Week, 86; 7,686 Medical Students Enter Medical Schools, 314; Darley Is New Executive Director of the Association of American Medical Colleges, 315; Research Building for University of Cincinnati, 323; OSU Medical Alumni Reunion Scheduled, 323; Admission Standards Are Re-Examined, 324; Medical Education Week Programs, 353; Educational Film on Diabetics Available from Ames Co., 464; More Than $3-Million from Ford Fund Goes to Western Reserve, 565; OSU College of Medicine Honors Four Alumni, 681; Foundation for Premedical Education at Wesleyan Headed by Dr. Perry, 712; Substantial Grant Aids Development at Western Reserve University, 718; New Requirements of American Board of Radiology, 838; OSU College of Medicine Announces Appointments, 838; Grant Promotes Psychiatric Studies at OSU, 950; Lectureship Sponsored at OSU, 958; Director of Council for Foreign Medical Graduates Named, 1062; University of Cincinnati Research Projects Promoted, 1062; Nutrition Study Among Projects Promoted at Western Reserve, 1068; Bunts Institute Announces Courses, 1186; Ohioans Will Participate in "Grand Rounds" Telecast, 1331; Eisenhower Asks More Funds for Medical Schools, 1441; Program Started to Relieve Shortage of Cadavers, 1453; New Council for Foreign Graduates Begins Work, ... 1470

Medical Licensure—(See under State Medical Board)

Medical Writing—
American Medical Writers Association To Meet, 1047; Cleveland Medical Writer Honored with Blakeslee Award, ... 1336

Medicare (Military Dependents' Medical Care Program)
Medicare Program in Ohio, 72; New Facts on Medicare Program, 210; Data on Medicare, 317; Medicare Interpretations, 563; Latest on Medicare, 689; Payments to Date to Ohio Doctors by Medicare, 690; Mutual of Omaha To Continue as Medicare Agent in Ohio, 825; About 1,200 Medicare Bills from Ohio Physicians Being Paid Monthly, 1179; Medicare Payments Running at $5,000,000 per Month Rate, ... 1472

Members, Roster of New—80, 214, 353, 468, 604, 696, 860, 1049, 1185, 1309, ... 1467

Mental Hygiene—(See also under Ohio Department of Mental Hygiene and Correction)
Ohio Representative Reports on AMA Mental Hygiene Conference, 315; New Mental Health Films Available from AMA, 827; Extensive Building Program under State Mental Hygiene To Start This Fall, ... 1067

Military Activities—(See also Medicare)
Orthopedic Surgery Is Subject in World War II Series, 202; Status of Medical and Dental Students Not Necessarily Changed by Recent Order, 219; Most Medical Students Subject to Military Service, 322; Growth of the Army Medical Service during World War II in Book, 328; Many Korean Conflict Veterans Eligible for Ohio Compensation, 453; Doctors' Draft Act To Die; New Measure Enacted, 834; Armed Forces Postpone Examinations and Induction of Doctors, ... 1179

Miscellaneous—
Cleveland Health Museum Honored on 20th Anniversary, 196; Deadline for Getting Special Auto Tags Is February 15, 197; Ohio Physician Is Featured on "This Is Your Life" Program, 589; Dr. A. Ashley Weech receives Borden Award, 845; Doctor's Orchestra of Akron Goes into 32nd Year, 1185; Battelle Institute Announces Research Program in Psychochemistry, 1186; Health Card Program Has Much Merit, ... 1259

Narcotics—
What To Do With the Drug Addict, 319; Narcotics Registration Must Be Renewed by July 1, 690; Don't Leave Narcotics in Your Auto, ... 1403

Nursing—
New Nurse Admission Procedure Instituted at Ohio State, 717; Physicians Who Need Nurses Invited to Use Ohio State Nurses' Association Placement Service, 1049; Information for Nurses on Holding License and Renewing the Same, ... 1077

Occupational Health—(See Industrial Health and Medicine)

Ohio, State of—(See under Department Categories)

Ohio Department of Health—
Medical Organizations Join in VD Seminar, 337; Antibiotics for Prevention of Recurring Rheumatic Fever Attacks Are Available, 474; TB Hospital at Nelsonville Is Dedicated, 580; Pamphlets Give Aids for Patients on Low Sodium Diets, 581; Revised VD Treatment Schedule Announced, ... 946

Ohio Department of Mental Hygiene and Correction—
Some Suggestions for the Future of State Agency Offered by Dr. Porterfield, 82; Dr. Porterfield Named to High Rank in USPHS, 464; Dr. Haines Named To Head Department, ... 1078

Ohio Department of Public Welfare—(See also under Aged, Aid for)
Mrs. Ireland, Mr. Minor Appointed to State Welfare Posts, ... 314

Ohio General Assembly—(See under Laws and Legislation)

Ohio Medical Indemnity—
OMI Reports Progress for Year; Elects Officers and Directors, ... 685

Ohio State Medical Association—(See also under The Council, House of Delegates, Annual Meeting)
Facts and Policies About Annual Dues, 218; Support Urged for New Section on Industrial Medicine, 470; Warning to All Members on Dues, ... 1439

Pharmaceuticals, Apparatus and Related Products—
Physicians Can Prevent Improper Use of Drugs, 94; Warning to Drug Firms on Distribution of Flu Vaccine, 1058; Serious Penicillin Reactions Increasing, FDA Reports, ... 1326

Physician's Bookshelf—18, 145, 266, 388, 518, 634, 753, 880, 992, 1116, 1250, ... 1386
Books of Historical Interest, ... 1162

Poliomyelitis—
Urges Stepped-Up Polio Immunization Program, 80; Polio Immunization Official Statement Adopted by The Council, 313; Shortage of Polio Vaccine May Slow Up Immunizations, 472; Agree U. S. Should Exit from Polio Vaccine Picture, ... 579

Postgraduate Activities—
Course in Diabetes and Basic Metabolic Problems Scheduled at OSU, 78; Bunts Institute Announces Course, 114; OSU Offers Course in Ophthalmology, 202; VA Schedules Clinics, 320; Northern Tri-State Medical Association Schedules Program, 320; Orthoptic Training Available at Ohio State, 459; Regional Conference on Hypertension Scheduled at Ann Arbor, 581; Occupational Skin Problems Subject of UC Course, 690; Ophthalmology Course Scheduled at OSU, 942; Fall Postgraduate Courses, 1044; Ohio Academy of General Practice, 1044; Pulmonary Diseases at OSU, 1045; Eighth District, 1045; Columbus Academy, 1045; Montgomery County and Second District, 1046; Sixth District, 1046; Northwestern Ohio Medical Association, 1047; Occupational Skin Problems, Cincinnati, 1047; American College of Physicians Announces Courses, 1180; Fall Postgraduate Courses, ... 1186

Prepaid Medical and Hospital Insurance—(See also under Ohio Medical Indemnity)
Increase Noted in Year's Payments from Hospital and Medical Insurance, 475; Twenty-five Years from Now? 834

Public Health—(See also Ohio Department of Health)
American Puhlic Health Association and More Than 40 Related Organizations Will Meet in Cleveland, 681; OSMA Staff Members Participate in Session of Ohio Public Health Association, 865; Dr. Porterfield Gets Promotion in USPHS, 1331; Health Commissioners Meet, ... 1332

Public Relations—
PR Committee Meets; Report Approved by The Council, 200; The Doctor and the Press, 325; You and Your Public—PR in Collecting Bills, 326; Few Words May Forestall Malpractice Litigation, 470; Wise Approach To A Knotty Problem (Having Family Physician), 700; The Medical Secretary, 706; Public Relations Institute in Chicago, Aug. 28-29, 834; AMA Television Programs Win Awards, 834; You and Your Public—Physician Establishes PR Through Three Sources, 975; The Press, Medicine and the Public, 1402; What's the Immunization Situation in Your Area? 1402; You and Your Public, ... 1465

Radiation—
Several Physicians Are Named on Governor's Advisory Council on Atomic Energy, ... 207

Rural Health—
Fulton County Youth Wins First OSMA Award in 4-H Club Health Contest, 92; Projects Sponsored by Committee—Preceptorship Plan, Extension of Lectures, 4-H Club Program, 197; OSMA Well Represented at AMA Rural Health Conference, 457; Rural Health—OSMA Activities Include Orientation Lectures, Preceptorships, 4-H Club Work, 686; "When You Begin Practice" Lectures Appreciated, 848; Preceptorship Program Is Outstanding Success, 1058; Rural Health Medical Scholarship Awarded, 1180

Scholarship, Rural Medical—(See under Rural Health)

School Health—
Pre-School Health—Expanding on Summer Roundup, 90; Committee on School Health Undertakes Special Projects, 196; OSMA School Health Guides are Revamped, 867; Continuous Supervision Is Most Effective Plan, 952; Conference on Athletic Injuries, 1058; Fitness Idea Should Not Be Overinflated, 1192; The New School Year and Recruitment of Health Personnel, ... 1259

Scientific Exhibits—
Roster of Exhibits for 1957 Annual Meeting, ... 458

Social Security—
Move on for Medical Care in Social Security System, 1190; Council Named To Review Financial Status of OASI, ... 1467

Socialization of Medicine—
Britain's "Dream" Medicine Is More Like a Nightmare, 95; Creeping Socialism in Small Chunks, 324; Welfare Costs Skyrocket, 336; Rules, Regulations and Controls, 952; Fitness Idea Should Not Be Overinflated, 1192; Conflict of Wealth and Welfare, 1402; Observations on Russia Related by AMA President, ... 1475

State Medical Board—
State Medical Board Examinations, 220; Licensed Through Endorsement by State Medical Board, 222; Licenses Granted as Result of December Examinations, 321; State Medical Board Makes Its Annual Report, 322; Licensed Through Endorsement by State Medical Board, 490; Support Ohio Stand Against Naturopathy, 579; Licensed Through Endorsement by State Medical Board, 599; June Medical Examination Questions, 940; Licensed Through Endorsement, 941; Two Named to State Medical Board, 943; Licenses Granted as Result of June Examinations, 1182; Board Suspends License of Dr. Joseph A. Geer, 1326; Licensed Through Endorsement by State Medical Board, 1333; Licensed Thru Endorsement, ... 1467

Story Behind the Word—300, 431, 560, 670, 787, 1038, 1433

Taxation—
Internal Revenue Ruling Appears To Split Hairs, 94; Internal Revenue Service Rules on Physician's "Earned Income," 808; Entertainment Expense Deductions, 969; Want Jenkins-Keogh Bill? 1440; Tax Roundup for Physicians, 1454; New Tax Ruling May Clear Way for Doctor Pension Plans, ... 1457

Technical Exhibits—
Roster of Exhibitors for Annual Meeting, 461

Tuberculosis—
Saranac Lake Symposium, 481; TB Hospital at Nelsonville Is Dedicated, 580; Course in Pulmonary Diseases at OSU (Correction in Report Noted, 866), ... 692

Unions—(See Under Industrial Health and Medicine)

Veterans Administration—
VA Schedules Weekly Clinical Conferences in Cleveland, 320; No More Hospitals Needed for Service-Connected Cases, 579; VA Plans Reduction in Paper Work, 701; Psychiatric-Neurologic Fees in VA Schedule Revised, 827; VA Makes Policy Change on Handling Workmen's Compensation Cases, 844; Veterans Administration Announces Clinical Conference Series, 1185; Columbus VA Area Medical Office Will Be Moved to Indianapolis, ... 1309

Veterans Affairs—
Many Korean Conflict Veterans Eligible for Ohio Compensation, ... 453

Vital Statistics—
Medical Men Can Help Reduce Highway Deaths, 94; Fourth and Fifth Child in Family Becoming More Popular, 202; Statistics Given for Mortality During the Past Year, 590; No Need To Pay Bonus for Birth Certificate, 848; Population Increase Challenges Medicine, 954; Birth Certificate Scheme Nipped, ... 1080

Washington Roundup—75, 203, 328, 476, 585, 694, 850, 965, 1064, ... 1196

Welfare—
Welfare Costs Skyrocket, ... 336

What To Write For—325, 471, 705, 866, 1195, ... 1489

Woman's Auxiliary—
Activities of Local Organizations, 110; 239, 346, 484, 601, 714, 862, 1341, ... 1486
Woman's Auxiliary Annual Meeting Program, 456; Auxiliary Will Meet in New York, 488; Woman's Auxiliary Annual Meeting, 586; Woman's Auxiliary Annual Meeting Report, 836; Today's Health Contest Brings Two Top Prizes to Ohio Auxiliaries, 939

Workmen's Compensation, Bureau of—
WC Fee Bills and Signatures, 76; No Need To File X-Ray Films, 77; Actuarial Report for 1955, 100; Chalmers P. Wylie Named Administrator of Bureau of Workmen's Compensation, 326; VA Makes Policy Change on Handling W. C. Cases, 944; Speed-Up in Payment of WC Medical Bills Planned; Send to BWC Your Ohio License Number for Coding, 1331; Bureau Actuarial Report for 1956, ... 1463

INDEX TO ADVERTISERS

Abbott Laboratories 1379, 1407, 1502-1503
and insert between pages 1484-1485

American Medical Education Foundation 1446, 1451

Ames Company, Inc. 1378

Appalachian Hall 1389

Ayerst Laboratories, Inc. 1485

Barry Laboratories, Inc. 1479

Bristol Laboratories, Inc. 1476-1477, 1490-1491,
and insert between pages 1388-1389

Burroughs Wellcome & Co. (U.S.A.) Inc. 1382,
and insert between pages 1404-1405

Chicago Medical Society 1481

Ciba Pharmaceutical Products, Inc. 1387

Coca-Cola Company 1380

Columbus Pharmacal Company 1498

Cook County Graduate School of Medicine 1514

Davies, Rose & Co., Ltd. 1487

Desitin Chemical Company 1504

Flint, Eaton & Company 1501

Geigy Pharmaceuticals, Inc. 1499

Harding Sanitarium 1390

Knox, Chas. B., Gelatine Co., Inc. 1408-1409

Lakeside Laboratories, Inc. 1373

Lederle Laboratories 1374, 1380, 1383, 1389,
1442-1443, 1451, 1473, 1505

Lilly, Eli, and Company 1412

Mallard, Inc. 1478

McMillen Sanitarium 1390

Medical Protective Company 1488

Merck Sharp & Dohme 1381

New York Polyclinic Medical School 1496

Parke, Davis & Company 1395, 1516,
and Inside Back Cover

Patch, E. L., Company, The 1497

Pfizer, Chas. & Co., Inc. 1392-1393

Pogue, Mary, School, Inc. 1484

Quincy X-Ray & Radium Lab 1489

Rich Company, Inc. 1493

Robins, A. H., Co., Inc. 1400-1401, 1473

Roche Laboratories, Division of Hoffmann-La-
Roche, Inc. ..... Insert between pages 1452-1453

Roerig, M. B., & Co. 1384-1385, 1447

Sanborn Company 1397

Sawyer Sanatorium 1404

Schering Corporation 1411

Scroggins, Clayton L., Associates
(Medical-Dental Management) 1496

Searle, G. D., & Company 1471, 1492

Smith, Kline & French Laboratories 1410,
and Back Cover

Squibb, E. R., & Sons, Division of Olin-
Mathieson Chemical Corporation 1396

Standex Laboratories, Inc. 1514

Stoneman Press 1498

Tutag, S. J., & Company 1492

Wallace Laboratories ..... Insert between Pages 1396-1397

Wendt-Bristol Company 1488

Windsor Hospital, Inc. 1482

Winthrop Laboratories 1398-1399,
1481, 1483, 1494-1495, 1500

Wyeth, Inc. 1391

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GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Feb. 10. Vaginal Approach to Pelvic Surgery, one week, Feb. 3. General & Surgical Obstetrics, two weeks, Feb. 24.

MEDICINE—General Review Courses, two weeks, Apr. 28. Electrocardiography & Heart Disease, two weeks, Mar. 10. Gastroscopy & Gastroenterology, two weeks, Mar. 17. Hematology, one week to be announced.

PEDIATRICS—Two-Week Intensive Course, May 12. Neuromuscular Diseases of Children — Cerebral Palsy, two weeks, June 9.

RADIOLOGY—Diagnostic X-Ray, two weeks, Feb. 3. Clinical Uses of Radioisotopes, two weeks, May 5.

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

GENERALIST to assume established practice in Lima, Ohio, immediately. Association to follow return of presently ill internist at undetermined date. Excellent opportunity financially and professionally. Harry Warshawsky, M. D., 523 W. High St., Lima, Ohio.

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Cincinnatians Named to Posts In Specialty Societies

Three faculty members in the University of Cincinnati College of Medicine have been notified of election to important posts in medical societies.

Dr. Richard W. Vilter, director of the Department of Internal Medicine, has been elected council member of the Central Society for Clinical Research. Dr. Johnson McGuire, professor of clinical medicine, is the new president of the American Clinical and Climatological Association; and Dr. John F. Mueller, assistant professor of medicine, is the new president of the midwestern section of the American Federation for Clinical Research.

Recent CD Publications

"Civil Defense for Adult Americans" published by the Adult Education Association in cooperation with the Federal Civil Defense Administration.

"Defense Guides for Commercial Food Facilities" prepared by U. S. Department of Agriculture. This publication can be obtained from Federal Civil Defense Administration, Battle Creek, Michigan.

"Office of Defense Mobilization Issues Statement on National Blood Program" Federal Civil Defense Administration, Battle Creek, Michigan.

"Now's the Time to Prepare for Hurricanes" reprinted from Factory Management and Maintenance magazine. Federal Civil Defense Administration, Battle Creek, Michigan.

"Procedures for Handling the Civil Defense Emergency Hospital" TB-11-30, July, 1957, Federal Civil Defense Administration, Battle Creek, Michigan.

"Suggested Reading List for Civil Defense Health Services" July, 1957, Federal Civil Defense Administration, Battle Creek, Michigan.

Many Foreign Physicians Come To America for Study

Ohio was among the 10 top states in training of foreign medical students last year, according to a report from the Institute of International Education. Throughout the nation 6,700 foreign interns and residents from 88 countries trained in American hospitals. Of this group, 4,753 served as residents and 1,988 trained as interns.

Cleveland Clinic was sixth in the nation among hospitals in the number of foreign physicians doing graduate work. There were 51.

The number of American students studying medicine abroad was 2,056 in 29 countries. Highest numbers were: Switzerland, 669; Italy, 319; Canada, 293; and Netherlands, 174.

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